MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 14, 2000
9:20 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
SPENCER JOHNSON
PETER KEMPER, Ph.D.
DONALD T. LEWERS, M.D.
HUGH W. LONG, Ph.D.
FLOYD D. LOOP, M.D.
WILLIAM A. MacBAIN
WOODROW A. MYERS, JR., M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
GERALD M. SHEA
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

P R O C E E D I N G S [9:20 a.m.]

DR. WILENSKY: Why don't we begin our Friday session. The first session is on payment policies affecting hospital outpatient departments and physician services. We're going to start with the outpatient department. Chantal, Susan, Kevin, whichever of you are the leadoff, please start.

DR. WORZALA: Good morning. We're here to talk about payments to hospital outpatient departments. As you know, the final rule governing the outpatient PPS was published in the Federal Register last Friday. It's a fairly complex payment system and we've had very little time to digest it.

Nevertheless, we hope to give a brief presentation that distills some of the central features of the PPS and the issues that arise from it.

This is the outline of the draft chapter that was included in your briefing materials. Our talk will be organized somewhat differently and in three sections. Susan will briefly review the design of the PPS, highlighting where the final rule incorporates changes introduced by the BBRA or by HCFA in response to comments.

I will then go over our analysis of the likely

impact of implementing the PPS, followed by a discussion of the draft recommendations in the chapter.

MS. PHILIP: There are certain elements common to most prospective payment systems and these are listed on the slide. Since we've gone laid out the details in your mailing materials, we won't go into those details right now. Though I will say the OPD PPS pays for a specific scope of services. It establishes a classification system for those services, establishes payment rates including beneficiary copays, and mechanisms for adjusting and updating the system and payment rates are specified in the final rule.

I'd like to highlight some of the main changes from HCFA's first round of rulemaking to the second. Some of these were changes made in response to comments from the industry and other interested parties, while others were made in response to the BBRA.

HCFA expanded the list of services that could be performed on an outpatient basis, including certain procedures that were previously only inpatient services. For example, certain insertion, removal and replacements of pacemakers. HCFA is planning to establish an advisory panel that will make recommendations to amend the list of approved OPD PPS services as deemed appropriate.

This group will also be involved in making recommendations to modify the classification system, such as changes to services that are included in a specific group or changes in the relative APC weight.

HCFA made changes to the classification system by collapsing and expanding a number of the APC groups. And the net result was it went from about 350 APC groups to about 450 right now. In changing the system, HCFA changed services in each group to comply with the BBRA's two times rule. That is a variation of costs of services within a group would now be greater than a factor of two.

This change expanded the number of groups and then HCFA also changed the way it classified evaluation and management services by no longer using diagnosis information. This actually reduced the number of groups substantially. This modification was in response to MedPAC's recommendations and a number of other comments that HCFA received.

Additionally, HCFA classifies certain services separately that were previously bundled, such as blood and blood products. The Agency also created separate APC groups for new technology services. As a result, the new APC grouping system is less bundled than the previous one first

proposed.

HCFA also made a number of changes related to payment in response to the BBRA. They established outlier adjustments which would pay for services associated with unusually high costs and they established traditional pass-through adjustments to be made for certain innovative drugs, devices and biologicals.

Finally, HCFA issues rules regarding transitional corridors that are designed to cushion hospitals as they move to a PPS. We've spent some time in your mailing materials, and also in last month's meeting, to go over these payment changes, especially the transitional corridors. So I won't be going into that right now but Chantal will go through the impacts of these payment changes for the next part of the presentation.

DR. WORZALA: Susan discussed the major elements of the PPS, which I think the final rule describes quite well. However, there are some aspects of the PPS that HCFA has not finalized. These all deal with the maintenance of the PPS over time, rather than the initial design of the system.

First, as Susan mentioned, there will be an outside advisory group established to assist HCFA in

reviewing the classification system and the relative weights on an annual basis. This is analogous to the RUC committee for the physician fee schedule. I just wanted to point out that none of the other PPS systems, the inpatient, SNF or home health, have an advisory group like this. So it is a bit unique in the PPS world.

The final rule included no details of who will be represented on the committee, how they will operate, or what their scope of authority will be.

Second, HCFA has announced that the update for 2001 and 2002 will be the hospital marketbasket minus 1 percent. No details have been provided on how future updates will be determined.

Here I think the issues are what is the best approach. Do you want to take an expenditure target approach or use an update framework similar to the inpatient PPS and what must be considered when you're setting the update on an annual basis.

Third, HCFA has authority to decrease updates in response to excessive increases in volume, but has chosen to delay doing so. They are currently studying alternative volume control mechanisms. At issue here is the trade-off between ensuring that the payment system does not discourage

appropriate shifts in care to the outpatient setting, resulting in increased volume while also providing a mechanism to counter the incentives inherent in the fee schedule to increase volume.

In practice, of course, measuring volume increases is also complicated by the need to account for anticipated coding changes in addition to real changes in volume.

These are topics that are likely to be the focus of our work in the coming year and we would appreciate hearing any thoughts you might have on these topics as we begin our preparations for the retreat. They are not, however, the subject of any draft recommendations.

Now we'll move from looking at the PPS per se to a discussion of the likely impact of the implementation of the PPS. This table shows the financial impacts of implementing the PPS on hospitals in calendar years 2000 and 2001. These are HCFA estimates based on simulations using claims data from 1996. The impact is shown as the annual percent increase in total payments to hospitals overall and by group.

In making these estimates HCFA made no adjustments for changes in volume and intensity or coding behavior. Under the PPS there will be an overall increase in total

payments to hospitals. This is in contrast to the impact table shown in the proposed rule, which indicated an overall decline in payments to hospitals.

Some differences in impact by hospital type can be seen before the transitional corridors are applied, which is the second column in the table. Most notable are negative impacts on small rural, large urban, and major teaching hospitals. Another category that is not on this table is volume, and there is an anticipated negative impact on low volume hospitals, those with less than 5,000 units, both in rural and urban areas.

After including the effects of the transitional corridors however, all hospital groups received greater payments under the PPS than under current payment law.

In addition to these financial impacts, hospitals will experience a substantial administrative burden while transitioning to the PPS. However, once the system is in place, hospitals will have a more unified, more equitable, and less complicated payment system.

MR. JOHNSON: Could you explain some of the significant administrative burden?

DR. WORZALA: I think the issue here is that billing systems will have to change dramatically. I'm not

that familiar with hospital administration management but my understanding is that there will be significant changes in how bills are processed and what the billing forms will look like, which will necessitate training and computer systems changes. That is exacerbated by the short period of time that hospitals are given to turn over to the new system that will be implemented July 1.

MR. JOHNSON: Are there any cost estimates for hospitals?

DR. WORZALA: As far as I'm aware, not that I've seen.

MR. JOHNSON: Going back to our conversation yesterday.

DR. WORZALA: Turning from hospitals to beneficiaries, we anticipate that there will be decreases in the beneficiary coinsurance. These come through two sources. First, the method used by HCFA to calculate the coinsurance amounts relied on median charges by APC groups rather than the mean values. Due to the distribution of charges, this led to an overall decrease in coinsurance of about 10 percent upon implementation of the PPS.

Due to provisions of the BBRA, this decrease is offset by increased program payments. It will not result in

decreased payments to hospitals.

Second, coinsurance will represent a declining share of total payments over time due to the buydown of beneficiary coinsurance. Nevertheless, in comparison to other sectors of the Medicare program, the beneficiaries continue to pay a disproportionate share of total payments for outpatient services. The average coinsurance rate across APC groups is 47 percent in the year 2000.

The buydown of beneficiary coinsurance will occur on a group-by-group basis.

DR. ROWE: I'm sorry, Chantal, could you explain that in a little more detail, for me at least? The average coinsurance for ambulatory care or for outpatient services is 47 percent in the Medicare program?

DR. WORZALA: That's correct. The methodology for determining that was to take the coinsurance amount divided by the total payment amount for each APC and then average it across APCs. So this is actually different from the average beneficiary share of total payments because it does not include volume and service mix changes. So it's really just looking at the payment schedule and the schedule of beneficiary coinsurance and averaging across services. It also does not include beneficiary deductibles.

DR. NEWHOUSE: So what would the weighted number be?

DR. WORZALA: I don't have available the volume and service mix so I can't tell you that. We understand that the beneficiary's share of total payments is around 50 percent so that the more common services actually have a higher beneficiary rate.

DR. WILENSKY: There's not a lot of difference. If the weighted number swung things by 10 or 20 percentage points, it would be relevant. 47 versus 50 is not going to be worth trying to find the weights to put on the numbers.

DR. WORZALA: Right.

MR. MacBAIN: The reason for this is because the copay is calculated on charges.

DR. WILENSKY: Exactly

MR. SHEA: That's the basic issue. This is just way out of line with the normal payment.

DR. ROWE: What are the percentages in the other parts of the program?

DR. WORZALA: 20 percent.

DR. WILENSKY: Jack, you understand why that happened? The 20 percent is applied to the charge, not to the Medicare payment. And that's what has led in the growth

in charges being so much more than the growth in payments in cost, that it has led to this coinsurance that's totally out of whack with everything else in Medicare.

DR. ROWE: I understand. I understand better now. Thank you.

DR. WORZALA: The buydown will occur on a group-by-group basis for each APC. Our estimate of the years required to achieve a 20 percent coinsurance rate depends on the annual update used in the calculation. The calculation is in the description to table 4.3 in your briefing materials.

I've shown two values here on the slide which are actually different from table 4.3 in your draft chapter. The 2.2 percent here is the update used by HCFA in estimating the regulatory impact of the PPS in the final rule. It's the estimated hospital marketbasket for 2001 minus 1 percentage point, which will be the update in 2001. The 3 percent number is arbitrary, but 3 percent is often used to approximate underlying average rates of inflation.

You can see that the lower annual update yields a longer period of time to reach a 20 percent coinsurance rate. That's 39 years versus 29 years for the 3 percent assumption.

Within that average there is variation among the APC groups. Some groups already have a coinsurance rate of 20 percent, such as the clinic visits. Other groups will take 50 years or more to achieve a beneficiary coinsurance rate of 20 percent, such as the computerized axial tomography scans, as shown on the chart.

In the future, new technology groups will have 20 percent coinsurance as they are added. I think that's an important feature to note, that as the system builds it will have a 20 percent coinsurance.

Upon implementation of the PPS, the Medicare program will have an improved payment system for outpatient services. It will be prospective, unified, and provide better measures for controlling costs. However, the outpatient PPS is expected to increase program costs.

These increased costs come through the use of a transitional corridors, the shift in liability from beneficiaries to the program due to the way the coinsurance is calculated, and the beneficiary coinsurance buydown over time. These increases are partially offset by previous reductions in costs for outpatient services through the elimination of the formula driven overpayments and the operating and capital cost reductions included in the BBA

and the BBRA.

You did see the effect of those provisions on outpatient margins in yesterday's presentation.

Finally, while the PPS represents a simplified payment system in comparison to the blended system currently in place, it is more complex than the proposed rule. Examples of additional layers of complexity include the outlier and pass-through payment adjustments, the transitional corridors and the hold harmless provisions for small, rural and cancer hospitals.

Before we discuss the specific draft recommendations, I would like to provide some context for the discussion, particularly since two of the draft recommendations have not been a focus of the presentation so far.

The first recommendation on beneficiary coinsurance buydown we just discussed. The draft recommendation regarding access to high quality care arises from three concerns. First, although the revised classification system narrowed the range of costs within an APC group, there's still variation that could lead to stinting on high cost services within a group.

Second, after 2003, the transitional corridors

will no longer protect hospitals from financial losses under the PPS. Thus, there is potential for access problems in hospitals experiencing financial difficulties. In addition, the transitional corridors do allow hospitals to experience some financial losses, so there may be some concern there as well.

Third, expansion of inpatient services paid for in the outpatient setting, such as the pacemakers, requires monitoring of quality for these services.

The third draft recommendation focuses on differences in payment for services across ambulatory care settings. Changes in technology, practice patterns, and the organization of medical services have led to provision of the same services in multiple ambulatory settings. Rates for the outpatient PPS are based on historical payments in the outpatient setting only. They are different from payment rates for the same services in other settings. And there is a table in your briefing materials that provides an update on what those differences are for selected high volume services.

There is, therefore, potential for concern regarding the role of financial incentives in determining where care is delivered and how facilities are identified

for purposes of Medicare billing.

Now I'm happy to either take questions or move on to a discussion of the recommendation.

MR. MacBAIN: A question about teaching hospitals and rural hospitals. Presumably, the impact, forgetting about the transitional corridors for the moment, the impact of the PPS is a reflection of the higher cost per service or per bundle of services in those institutions. I wonder if it would be worth, in the case of teaching hospitals, if it would be worthwhile doing something analogous to the IME regression, to try to identify the empirical value of a higher cost for APC in a teaching setting.

In the case of rural hospitals, I assume we're dealing with the diseconomies of scale of low volume. To do something analogous to the IME regression for both inpatient and outpatient services, again to try to establish the empirical value or the empirical cost over and above what we're deeming the cost of an efficiently run facility in a low volume rural setting.

DR. WORZALA: I think those analyses might be useful. One thing to point out is that the estimates that HCFA presented are based on 1996 claims data, and so I think it probably needs a year experience, in order to get data

that includes new services, but I don't disagree.

MR. MacBAIN: My concern though is the transitional period is not a very long period and the dollars involved here, for both teaching hospitals and rural hospitals, bespeak some real risk for those institutions. If it is just a reflection of inefficiencies, then that's something they have to deal with. But if it's something structural, as we've said is true with IME and teaching hospitals, then it seems to me it may well be true both for teaching hospitals and for rurals, for both inpatient and outpatient.

We really ought to highlight that, or we're going to end up with a payment system that does harm where it shouldn't be doing harm.

DR. WORZALA: Yes, in the proposed rule, HCFA's regression analysis did not show that teaching status had any systematic link with how hospitals would fare under the PPS, but that was using the proposed rule not the final rule.

DR. NEWHOUSE: I also was going to ask about GME, so could you say a little more about teaching status. There was a teaching hospital dummy variable of some sort in this regression, and that showed no effect on cost?

DR. WORZALA: That's correct, it was not a significant variable.

DR. NEWHOUSE: Can you circulate what HCFA did here?

DR. WORZALA: Sure. As I said, this is from the proposed rule, not the final rule. There is no such emphasis included in the final rule.

DR. NEWHOUSE: Then my follow up, are either we or HCFA planning any further analysis of medical, the GME payments in the outpatient setting? And what's the HCFA work plan? I see Deb Williams nodding her head.

DR. WORZALA: I'm sorry, I'm not actually aware.

DR. NEWHOUSE: Can you find out?

DR. WORZALA: Sure.

DR. NEWHOUSE: Then we should probably put this on our retreat agenda as well.

Then I had one comment and one other question. On page five you say additional payments for certain drugs and devices undermines the goal of creating incentives for efficient use. Well, it's also the case that no payment for certain drugs and devices undermines incentives for efficient use. We've always embraced the principle of paying marginal cost of the efficient provider and that

should be reflected here.

Finally, one question. I wasn't clear from the chapter about what the updates were for the small rurals and the cancer hospitals.

DR. WORZALA: Right. The way those hold harmless provisions work is that the hospitals will operate under the PPS and then there will be a determination of whether or not the hospitals are faring as well under the PPS as they would have fared under previous payment policy.

If they're faring better, they keep whatever gains. If they're faring worse, they get an additional payment that takes them all the way up to the level of payment they would have received using the prior payment rules.

DR. NEWHOUSE: But the prior payment rules with no update factors? How is that determined?

DR. WORZALA: The higher payment rules are established by using the cost to charge ratio that's determined from the 1996 data. That cost to charge ratio is then applied to the cost incurred in whichever year you're looking at.

DR. NEWHOUSE: It would probably be the charges

DR. WORZALA: So for example for 2001 it would be

the 2001 --

DR. NEWHOUSE: The 2001 charges you mean?

DR. WORZALA: Correct; right.

DR. MYERS: Could we talk a little bit more about the billing process and procedures as this change takes place? For instance, are providers still going to use the HCFA 1500 form? Or will there be a different form? Are there going to be new data elements required compared to today? And what are those data elements going to be?

I think this is a serious issue, as to what the costs are going to be for putting such a system in place. If you imagine all the Medicare patients evolving in this direction, the hospital outpatient departments and the providers providing care are not used at all to those kinds of changes. There's going to have to be a lot of new software developed, and they're going to have to maintain dual system. Because others are not going to evolve as rapidly at all towards this system.

So I'm wondering about the administrative burden here. I don't think that's a trivial issue and you probably ought to really look in much more depth at what does this mean with respect to that burden? And how are we going to help providers adjust? What types of transitional policies

will there be, because there will be some folks that will be concerned that what might look on the surface like abuse or fraud really isn't, it's confusion on someone's part about the billing system.

So I think there are a lot of issues surrounding the administrative issues that should be looked at in much more depth. And we should perhaps at least consider a recommendation that an active vigorous look at what we can do to ease that transition administratively, and then reduce any unnecessary costs associated with it, should be considered.

I didn't mean to interrupt your answer.

DR. WORZALA: Would you like me to respond to that?

DR. MYERS: Yes, if you would please.

DR. WORZALA: I will tell you what I do know, which is that the hospital community is concerned about this and that HCFA is doing what it can in terms of providing free training on the new system and moving very rapidly to train its fiscal intermediaries to use the new system, which I know has also been a concern of the hospital industry.

They say that it's the most intensive, extensive training effort that they've ever undertaken, using lots of

different media, World Wide Web, videos, et cetera.

Now I'll tell you what I don't know, which is I really am not that familiar with the administrative side of this. The rule came out last week Friday. I've been working on this issue for a few months and I would appreciate guidance from the commission about where to look to learn more about this.

MR. JOHNSON: Looking at your list of recommendations that involve the benefit coinsurance buydown, beneficiary access, and consistency of payment, I would propose a fourth recommendation. Since it's not on there, I'll just speak to it now and we can see how people feel about it.

The Secretary should report on the unintended or financial hardships that affect access and quality due to this regulation, because we've already, I guess, identified two of our three or four favorite candidates on the vulnerable hospital list, teaching hospitals and rural hospitals. And while we're busy protecting the beneficiary interest here, I think it's also in the beneficiary interest in some of these areas to ensure that we're going to continue to have access and that this payment system is a barrier.

So I would suggest that additional recommendation in the report.

DR. WILENSKY: I'm not sure -- I need you to repeat so we can put up and look at a recommendation before I feel comfortable considering it. So if you want to circulate it and we can look at it early this afternoon and decide whether we want to include it, I'd be glad to do it.

MR. MacBAIN: This may have been in the text and I just forgot it, but does the calculation of the APC rates include an adjustment for anticipated upcoding?

DR. WORZALA: No, it does not.

MR. MacBAIN: Do you expect any? Is this an upcoding proof system or is that likely to happen?

DR. WORZALA: Given that they have an update factor that's a straight marketbasket minus one percentage point, the mechanism for responding to upcoding is not there. As I mention, past 2002, there is no update mechanism established in the system, so I think that's an issue we need to speak to for the future.

MR. MacBAIN: What is the marketbasket? Is it the same as the inpatient marketbasket?

DR. WORZALA: That's correct.

MR. MacBAIN: Is that a good analogy? Do we have

any sense of whether that's the right mix of goods and services?

DR. WORZALA: Those who have looked at it seem to think it's relatively analogous. HCFA did, when it put out the proposed rule, ask for comment on whether or not people thought it was appropriate. And they received no comments that it was inappropriate.

DR. LEWERS: I agree with Woody and Spence and the sense of Spence's recommendation. The problem with a lot of regulations is the hidden cost, and the hidden cost is usually administrative. And the changing today of systems, and doing it every two to three years, many hospitals and many physicians have changed systems recently. Now we get a new system and so the cost is dramatic. I think addressing that is certainly appropriate.

I'd like to go back to Joe's point on page five, because I think there's an area there that clinically, to my way of thinking as a physician, doesn't make sense. In the middle of the page there's a sentence that says the ability to bill separately for additional incidental items and services, such as blood products, could lead to increased use of these services.

I won't disagree that there are certain services there that will be increased, but probably the last one which would be increased would be blood and blood products. So that certainly is an indication that clinically we don't understand the impact of all of this.

So I think that certainly needs to be changed. Certainly blood products is the last example I think you want to use. I think there are a couple of areas you want to read through and make sure that you are indeed talking about products that would be increased.

Splitting and strapping possibly, but not blood.

DR. ROWE: It also implies a degree of mistrust and probably -- I'm not trying to be Pollyanna here, but it probably goes beyond the pale a little bit. I mean, there's no doubt there are incentives for utilization of services, but to do a transfusion that's not necessary because you're getting paid for it, doesn't sound like somebody who's in the same fraternity I want to be a member of.

DR. WORZALA: Point taken. I think my intent was to demonstrate that the principle of having a bundled payment which provides a lump sum for a particular procedure or service is diminished when you start paying for certain elements under that bundle separately.

DR. NEWHOUSE: That's exactly what I was objecting to. I disagree with that. We generally disagree with that in the rest of our philosophy.

DR. WILENSKY: If the pricing were at the margin, then it's not a problem. It's only since we don't really know really what the marginal cost is that, in the presence of a higher than marginal cost in an unbundled service, we have an incentive to use more. So you just ought to qualify why you're concerned about this.

DR. NEWHOUSE: Marginal cost is usually not zero either.

DR. WILENSKY: But having said that, having a clinically appropriate example would make us look less silly.

DR. LOOP: I wanted to ask on that third recommendation that we're not leading to inappropriate shifts in where care is provided. Give me an example of an inappropriate shift. I think we talked about this one time before, but could you just renew my thinking on this?

I mean, who determines what's inappropriate and give me an example of what could be an inappropriate shift in care.

DR. WORZALA: Just let me ask if we want to step

back and actually put the draft recommendations up before we entertain questions?

DR. NEWHOUSE: Basically sending a service here or there for money reasons.

DR. ROWE: The service isn't inappropriate, it's the site at which it's given that's inappropriate. That's the ambiguity. I think what they're trying to say that the service is an indicated service but it's just being done in the outpatient department because the reimbursement is better, and actually it would be more appropriately given somewhere else.

DR. LOOP: Then why don't we say site of care?

DR. ROWE: I don't want to speak for you, Chantal, but that's what you mean, right? It's the site that's inappropriate, not the service?

DR. WORZALA: That's correct.

DR. NEWHOUSE: Both sites may be appropriate, but you're basically just determining the site to maximize revenue.

DR. WORZALA: Do we want to talk about the specific wording of this draft recommendation right now?

DR. WILENSKY: This actually was to let people talk in general about what was presented, and we'll go

recommendation by recommendation.

DR. NEWHOUSE: I seem to be following along in Bill's footsteps today on this. Yesterday we made an update recommendation in part on the basis of a study of coding that HCFA had done for '97, '98, and '99. I wonder if they have any plans for doing an analogous study on the outpatient side? And if not, whether we should recommend that they undertake such a study?

DR. WORZALA: I'm not aware of their work program in that area, but I could certainly find it out.

DR. NEWHOUSE: I don't have the wording but I suggest that we include that in our recommendations, then.

DR. ROWE: Can you explain to me briefly why the payments in psychiatry are changing so dramatically? Table 4.2 in your chapter, there are all the projected changes, with or without the transitional corridors. Some are great and then others, but they fall within a kind of distribution.

And then these changes in psychiatry are dramatic in their increases. There's a 21 percent increase without the corridor, and then they add the corridor for some reason, I'm not sure why, and they go up to 28 percent. Why is that? Do we know?

DR. WORZALA: In the final rule HCFA says that they're not particularly confident about their estimates for some of these TEFRA hospitals because of the way they billed in the past is different from the way hospitals were billing. So for example, they would have more of a per case payment methodology, so that they may not be getting the proper cost per individual service delivered the way they do in the hospital outpatient setting.

DR. ROWE: So these should be in parentheses.

DR. WORZALA: Yes, we should qualify those.

DR. ROWE: Because if you're worried about "inappropriate" reallocation of care to different sites, it seems to me it would be particularly in these, where the numbers are so dramatically different, that there should be special monitoring or something.

DR. WORZALA: Right. Now this table, Table 4.2 is showing the overall impact on the hospital. It's not showing the change in the payment rate for a particular service. I just want to make that distinction.

DR. NEWHOUSE: So do you mean this could be either price or quantity change, or both?

DR. WORZALA: Right, or it could simply be coding.

MS. RAPHAEL: This is kind of looking at the issue

of administrative burden from the perspective of continuing to try to break down silos and ensure consistency because I think this is an issue that should be looked at across sectors. I know in the post-acute care sector, in the course of two years, we've made major investments to change to an interim payment system, and now are making huge investments to move from billing per hour and visit to billing for an episode of care.

I note in the SNF world there also were investments in terms of that PPS system. So I think we ought to make sure that we consider it in a broader way.

DR. WILENSKY: Consider?

MS. RAPHAEL: If we say that the cost for doing this ought to be, if we come to that conclusion --

DR. WILENSKY: Why don't we wait to see that. Absolutely. The fact that there was going to be a movement to a prospective payment system for the areas in which there was substantial growth in expenditures, outpatient hospital, home care, and skilled nursing facilities, is something that has been on the table since the mid to late '90s, for a long time. And this ought not to have come as a big surprise.

Whether and how much the government ought to be assessed a fee for, or charges for covering, is something we

can discuss. I think that this is an issue, to the extent we want to talk about, if there is an indication that it is the result of particular changes, there's an access problem, that's one thing.

My sense is that in terms of update factors, we tried to deal with the general issues that we thought were important in this area, we'll come back and talk about some of the regulatory matters. I think it is something that we want to both be consistent with and be thoughtful about before we just add on.

Because I think this is something that while the time frame is very short that hospitals are given, unreasonably short, the issue that the hospitals were to move to an outpatient prospective payment system as a result of the Balanced Budget Act is something that's had several years notice. And again, as you said, whether or not we want to make a statement about whatever financial impact it will have, it is not unique to this area. So we will when we take that up.

We have several recommendations, why don't we move now to the recommendations we have on the table and get a sense of how you feel about them. We also have some revised recommendations from yesterday, but maybe we'll go through

the morning and then take them up. And then if you want to offer another recommendation, we can look at that.

MR. JOHNSON: I think I can incorporate my recommendation [inaudible].

DR. WILENSKY: Okay. First draft recommendation, do you want to go through it?

DR. WORZALA: First draft recommendation, the Congress should enact legislation to accelerate the rate of beneficiary coinsurance buydown under the outpatient PPS and establish a date for achieving a coinsurance rate of 20 percent.

DR. NEWHOUSE: Don't we mean an earlier date? I mean, we've seen dates. I don't think we mean just establish a date.

DR. WORZALA: The point is when the buydown would be completed really depends on the update. There is no date certain by which this will be accomplished. Perhaps I should say a date certain.

DR. NEWHOUSE: A date certain, right. That would be good.

DR. BRAUN: I think that is great but I'm wondering if we either should add to that recommendation or do a separate one that would say something like the

Secretary should assure that the phase down is effectively monitored and enforced. Because I think, from our memories of the balanced billing limits and so forth, and the difficulties in really getting that enforced and monitored and so forth, that we may have the same problem here. It would be good to get that into a recommendation.

MR. SHEA: I wonder whether it wouldn't be appropriate to go beyond this, at this point, and talk about getting this schedule into some realistic time frame. I mean, we talk about implementing, or the program implements changes on the provider side in what, two years, three years, five years, six years.

And yet here it comes to an important beneficiary benefit and we're talking like triple that, or quadruple that. I just think it's time to say that this ought to be really in the same time frame.

DR. WILENSKY: Let me make a suggestion. I don't disagree with that, but I'm a little concerned about making a specific -- I mean, I agree with the spirit of what you're saying absolutely. I would feel a little better, and maybe you know the answer to this, of saying that it ought to be done within a specific time frame, if I had some idea of what I was about to spend.

I mean, I don't object to saying it ought to be done within 10 years or 15 years or seven-and-a-half years. But I have no idea when I'm making that statement now, about when I'm saying.

So I would like to, unless we have those numbers in time to do something right now, I guess for right now I would like to say by a date certain and in a time frame that is more aligned with other changes in the Medicare program. I'm just uneasy about saying what it is.

MR. SHEA: I think that's fair, but I think you're exactly right, Gail, in terms of looking at this. Get it more within the framework of the other changes that are made, instead of just being an exception. For beneficiaries we'll do something kind of crazy.

DR. WILENSKY: Maybe we can go up to 10 years in our changes. In the past we have some changes that phase in over 10 years. We have most of our transitions that are three to five years. I would just like to see what it is we're asking Congress to spend if we were to do something within five to 10 years, instead of having it whenever it is.

MR. MacBAIN: Does the Commission has the ability to come up with a range of estimates with different update

factors, so we can get a sense or sort of a matrix, with this update factor, five years would cost X, 10 years would cost X, and the same with a different update factor?

Not necessarily for this report, but for the next time we revisit this, for next year's report, so we can be a little more definitive and say this ought to be done within 10 years and here's what it will cost and Congress ought to appropriate the money.

DR. WILENSKY: Our staff was nodding yes, so I assume the answer is yes, we can do that.

DR. WORZALA: It should be something that we can work on.

DR. KEMPER: I wouldn't minimize the importance of the budget impact, but we don't make budget impacts for most of the other things that we do, in terms of making recommendations. So I'm not sure why we should single this one out as one where we have to pay particular attention to the budget impact. We didn't do that on the update.

DR. WILENSKY: No, but we followed -- I think that's not an accurate analogy. We have a specific format that we follow with regard to the update, and we went through and looked at each of the components, as we always do, used our discretion to postpone any recruitment from the

unbundling which would have been otherwise a calculation and came up with a number that reflected a strategy that we had gone through in accordance to something that we've been asked to go do.

In general, I think we've been very reticent about making specific recommendations that increase net spending on Medicare. This is an issue that we've talked about, but we have talked about it in very general terms. And I think if we are going to make a specific recommendation, to put more specificity as Gerry has been suggesting, that it's appropriate.

At this point, I don't know whether we're talking about, within Medicare's realm of numbers, a relatively modest amount or are we talking about a quite significant increase. And I just think that if we're going to make something as specific a suggestion, that we ought to take it down in five years or eight years, I'd like to know whether we're talking about $2 or $3 billing or $10 or $20 billion.

I think it behooves us. And then we can decide what other kind of statement we might want to make around it. But I think we've actually been very cautious about making recommendations that are net increases with any specificity.

MR. SHEA: Gail, I think your suggestion of getting it into the same timeframe or roughly the same timeframe as we do for other changes in the system is the right step to take at this point.

MR. MacBAIN: Just to follow up on Peter's point, at least in my mind, the difference here is that changing the copay from one based on charges to one based on payments is technically changing benefit. And that is different from changing an update factor.

DR. WILENSKY: I would like to, I think, on this if you don't mind, I think you have a sense of the modification we'd like on this. It's important enough that we'll look at this again either late this morning, first thing in the afternoon, as to precise wording difference.

DR. WORZALA: Maybe I can reiterate what I think I've heard. First is to establish a date certain for achieving a coinsurance rate of 20 percent. That's one thing. I'm not quite sure if I'm modifying this in any way in response to Bea's comment about effectively monitored and enforced.

DR. HAYES: I had something on that. My impressions, given what Bea said, was that would require a separate recommendation and I just scratched out something

here like the Secretary should monitor implementation of the PPS to ensure the required buydown of beneficiary coinsurance payments. Is that the kind of thing that you were thinking about?

DR. BRAUN: Yes.

DR. ROWE: Does it make sense to put like a maximum period? The cap should be no greater than X years, even though we don't know exactly how much we're spending.

MR. SHEA: Again, I think the notion of rough parity here is at least what I think is fair. I think what they've got here is just way out of line. Without getting into a specific number, if we could say a date certain that is within -- that is consistent in terms of timeline of other major changes that are made in the Medicare system or something like that.

DR. WILENSKY: I agree with that. I would feel less uncomfortable with that.

MR. MacBAIN: I'd like to see us actually, not this year but next year, include a specific time on a recommendation, but in the interim get a sense of what the cost would be, and include the cost in the text next year. I just think this is one year too early because we don't have the data to support it.

DR. WILENSKY: While you're working on the new recommendation, that struck me as a place to at least put in the concern we raised yesterday with regard to access, when we were talking about GME. As opposed to the administrative costs per se, which I think takes us down a whole different route, indicate that the Secretary ought to be monitoring any impact that the move to outpatient prospective payment has on access to care for seniors. Because that is really why we worry about issues of administrative cost or complexity and what it does for the hospitals.

MR. JOHNSON: That's draft recommendation number two.

DR. NEWHOUSE: Two is really site of care.

DR. WILENSKY: No, I thought in keeping with the new recommendation that Kevin is drafting, maybe.

DR. WORZALA: Shall we go on?

DR. WILENSKY: Why don't we go on to the next one. The question is whether this next one can incorporate -- whether you want a separate recommendation or whether it can be incorporated in here.

DR. NEWHOUSE: Can we have some specific mention of beneficiary access to services in number two?

DR. WILENSKY: Yes.

MR. MacBAIN: It says, monitor beneficiary access.

DR. WILENSKY: It's less the issue -- I guess when I read that, that was more like a generic statement that you could drop it in at any point, in any service in Medicare. What we're concerned about here, I think, and it may be that it's implicit in what we're saying, it's why I didn't catch it to reflect what Spence was raising, as a result of the substantial change in the reimbursement system, we think it's important for the Secretary to monitor any changes in access to care that seniors may experience.

DR. NEWHOUSE: And the text should probably explain that bundling could diminish, or lead to stinting, diminish access to certain services.

DR. WILENSKY: I think also include the issue that Bea had raised, as part of monitoring the access to care, monitor that the buydown in coinsurance also occurs. We made a distinction the last time that we had an implementation recommendation. This seemed, to me, to be close but not quite to what we were talking about in terms of the implementation regulation.

DR. ROWE: You should change the wording here because it sounds like the alternative is that the Secretary should not bother monitoring the low quality care. We're

asking her to carefully monitor the access to the high quality care.

So what we probably should say is she should carefully monitor the quality and access or something like that.

DR. WORZALA: Something like access to and quality of.

MR. JOHNSON: Before we wordsmith it to death, this is where I was going to offer my amended recommendation. The Secretary should carefully monitor the implementation of the outpatient PPS system to ensure that it does not have unintended adverse consequences on beneficiaries or providers. And then, in the chapter language, the access and availability to high quality outpatient services to the beneficiaries, and at the same time, probably the biggest impediment to that might be financing and the system that's been implemented.

And looking at the hospitals we had yesterday, in the chapter language on outliers and GME, I guess our favorite category of rural, teaching, and Medicare dependent. But in the chapter we talked about the ability of providers to finance higher quality outpatient services.

DR. WILENSKY: Those are not recommendations. I

would not like to see that in the recommendation. I think the recommendation ought to focus on access to care and quality of care that seniors receive. I think it's perfectly appropriate again, as we did yesterday, in the text below it to indicate that these changes could have unintended effects on providers.

But the focus of the recommendation is that the Secretary's monitoring is not to monitor what goes on to the providers, but to monitor what happens to the access to care that the seniors receive. But I do think it's appropriate for text language, and then it also makes it -- as Carol was raising -- consistent with the kind of discussion that we had yesterday. At least I think it's consistent, where the recommendation focused on access to care and the text discussion raised concerns about certain vulnerable institutions and what might happen to them.

MR. JOHNSON: I guess I would only respond, and I would let it go if you feel that way, that I find it unusual that we wouldn't also monitor what's going on with providers. When you look at the number of recommendations we're making, when you look at the number of changes that Congress is making, somewhere there's got to be some accountability here to look at these things.

DR. WILENSKY: I'm giving you my sense but obviously this is a question for the Commission. If we find an impact on access, that's an issue. If we find there's an impact on providers but that patients seem to be getting access to high quality care, that's a different issue. And I think that's why having the recommendation focus on monitoring access to high quality care for seniors ought to be the focus of our recommendation and discussion in the text about the fact that there's a lot of change going on in providers is perfectly strong.

That is also, it seems to me, consistent with where the Commission has come out in these other recommendations.

DR. BRAUN: I think in the phase-down monitoring we should also say monitoring and enforcing the phase-down because I think that's important.

DR. LEWERS: I look at Spence's recommendation I guess a bit different than you do because I think the impact on providers will be felt before the impact on access. I think it's an early warning sign. I think that's where you're headed and I think it is appropriate somewhere at least to reference that. I haven't seen the language. It sounds reasonable to me.

But the problem with just a statement such as this is we're looking at access, but that's not where we need to start. We need to start trying to find the parameters that are going to be the early warning signs. And I think the impact on providers is one of those signs.

We aren't addressing that. I'd rather see them monitoring that in addition to access. So somehow I'd like to see that wording come in somewhere. I just think it's important.

DR. WILENSKY: Again, I guess I'd like to get a sense of where the Commission is. Yesterday we made a distinction, when we made our recommendation with regard to hospitals and GME -- and I think I'm reflecting this accurately -- that the recommendation included the focus on the access to care for the seniors. And the discussion under the recommendation in the text talked about monitoring what happened to particularly vulnerable hospitals that we're worried might have it.

And what I'm suggesting is that we follow the same distinction as to what goes in the recommendation or not.

MR. MacBAIN: Can I try different wording on it? The Secretary should carefully monitor implementation of the outpatient PPS to assure that it does not have unintended

adverse consequences for providers or threaten beneficiaries' access to care.

DR. NEWHOUSE: The problem is that there can be other things that threaten beneficiaries access.

DR. WILENSKY: The focus here is trying to say you're introducing prospective payment system, and it may be that there's something about the prospective payment system that threatens access to care and the providers are doing just fine, as at least it indicates. From what we have here, financial concerns ought not to be early year concerns from outpatient PPS.

The numbers that we're showing do not indicate that this is a big financial hit. In fact, it's a financial plus. We could still imagine problems with getting access to care.

DR. NEWHOUSE: Stinting would help the providers.

MR. MacBAIN: But that's an unintended adverse consequence that effects providers.

DR. NEWHOUSE: But it helps the providers.

DR. WILENSKY: It's not an adverse. That's why, to my mind --

MR. MacBAIN: It's adverse for the program.

DR. WILENSKY: I think we're taking what ought to

be a pretty straightforward concept which is our focus is not on making this a provider issue. Our focus is on access to care. And obviously, if the whole provider system collapses, you will have access to care problems.

But the focus ought to be on the access to care to seniors and to indicate we're doing a lot of change and seeing what happens and looking at what's going on in the provider community as a potential early warning signal, or deciding that, in fact, the early warning is something of what's going on in the private sector and it's not an Medicare issue which may or may not impact access.

But it's really the question of what it is we're focusing on.

MR. MacBAIN: I think Ted's point is a good one. The effect on providers and the providers response is going to tell us something sooner than trying to directly measure access changes. By then it's too late, the damage has already been done.

DR. WILENSKY: I guess the issue is the one that Carol raised, is that this is a very different focus than I think we took in nursing home, and that we took in home care, and that we took in the Medicare+Choice, all of which you could make the same arguments.

MR. MacBAIN: I'd like to learn something from that.

DR. WILENSKY: But we've just been making these recommendations. So I'm just a little uncomfortable making a distinction here that we have not done elsewhere, in terms of the recommendation. Peter, and then we can just do a vote, of do you want to follow what has been suggested in terms of including in the recommendation, either with this wording or not? Or would you like to follow what we were using yesterday? Whatever the majority would like is fine.

DR. KEMPER: I agree with Gail, in terms of the actual recommendation language. But I think it's very important in the text to recognize that we're not going to have services if the providers aren't thriving and have administrative systems that are implementable, and that there are a whole set of things that we're doing that could lead to withdrawal from the market or problems in the markets. And that that mindset needs to be reflected in the text and what we say, throughout what we're doing.

And I think we do pay attention to that in other things that we do. But I think that's probably not reflected in what's here now and that could be strengthened.

DR. WILENSKY: I agree. Let me try. I think the

question is not a sense of disagreement that it's an issue. It's a question of do we put this wording in the recommendation or do we put the recommendation or focus on access to seniors and put the concern about what may be going on to providers in the text?

MR. SHEA: Gail, I think you're right, and I agree with Peter's formulation. But I think it ought to be strong in the text, particularly in light of the recent experience in the other changes. I think that's only fair.

DR. WILENSKY: I agree, and it's not there. Now I guess the question is how many people would feel comfortable with what Peter and Gerry have just suggested, which is keeping it in the text but in strong language in the text?

DR. WORZALA: Can I recap specific language for the recommendation before we move on?

DR. WILENSKY: If you can.

DR. WORZALA: The only change I would make at this point is beneficiaries' access to and quality of outpatient services.

DR. WILENSKY: I think that you ought to take a minute to just try to rephrase it. Part of the issue is let's try to have a crisp recommendation, and then the real concern will be making sure we capture the sense of the

group, in terms of what's in the text.

DR. HAYES: So we'll be revising this and giving you new text, we hope before we leave today to review. Does that sound all right?

DR. WILENSKY: If you can do it. If you can do the text before we leave that would be terrific. At the very least, I think we ought to see the recommendation before we leave and the text afterward. If you can do both, that's even better.

DR. WORZALA: The final recommendation that was included in the draft chapter, the Secretary should monitor changes in practice patterns across ambulatory care settings to ensure that differences in payment are not leading to inappropriate shifts in where care is provided.

DR. WILENSKY: Site of care.

DR. WORZALA: Sure.

DR. NEWHOUSE: I've suggested a recommendation that the Secretary undertake a study of upcoding similar to what is done on the inpatient side. We ought to work out the wording.

DR. WORZALA: Is that as a modification?

DR. NEWHOUSE: No, it would be a separate recommendation.

DR. WILENSKY: Again, we want to see this language before people go, so they can be comfortable with any new recommendations.

Kevin, the conversion factor. I think we're done with this.

DR. HAYES: In your mailing materials for the meeting you have a draft chapter on updating payments, estimating payment update for physician services. The payment update we're talking about here, of course, is the update for the physician fee schedules conversion factor.

You might ask why we're proposing this chapter, and we can look at the next slide and realize that in the Commission's March 1999 report, the Commission made a recommendation that the Congress require the Secretary to publish an estimate of conversion factor updates by March 31st of the year before their implementation.

The Commission's rationale for adopting this recommendation was that issuance of a preliminary estimate of the conversion factor in the spring of each year would give the Commission and others an opportunity to review and comment on it. Then later, the final update for the conversion factor would be released in the fall of each year. Historically, HCFA has been issuing that update late

October or early November with implementation to occur January 1st and there had been no opportunity for review and comment on the update.

The Congress considered not just that recommendation but four others that the Commission made with respect to payment updates for physician services and the sustainable growth rate system that is used to determine those updates, and took action on all five of those recommendations.

In the case of the preliminary estimate of the update, they required HCFA to release an estimate by March 1st of each year. The Commission must review that and include comments on the estimate in its June report, and then the final update is issued by November 1st.

So if we look now at what the preliminary estimate of the 2001 update would be, we see that HCFA is estimating that to be, at this point, 1.8 percent. To put that kind of percentage in some perspective, the update for this year, for the year 2000, was 5.5 percent. In 1999 it was 2.3 percent.

We get to this 1.8 percent by looking at the different components of the update, which include first the estimate of the Medicare economic index for next year, which

is 1.7 percent. The MEI measures changes in the inputs used to provide physician services. Things like physicians' earnings, supply, rent, so forth.

Another component of the update is what's known as the update adjustment factor. Recall that updates for physician services are unique in that they take into account not just increases in the cost of providing services but also the extent to which spending for physician services has been above or below allowed levels.

We'll come back to this update adjustment factor in a minute, but suffice it to say for now that the estimate of what that will be for next year is 0.5 percent.

The update estimate also includes two other what you might think of as budget neutrality adjustments. The first one is labeled here as a legislative adjustment, which was required by the Balanced Budget Refinement Act of 1999. The second is a volume and intensity adjustment. This is in anticipation of volume growth associated with implementation of revised resource based practice expense, relative value units, and the physician fee schedule.

HCFA actuaries estimate that the effect of those volume increases would be a 0.2 percentage point increase in spending, and so this adjustment offsets that.

Going back now to this question of the update adjustment factor and the fact that it is determined by the difference between allowed and actual spending, recall that allowed spending for purposes of physician updates is determined by what's known as the sustainable growth rate. This estimate of that for the year 2001 includes the factors that you see listed here, a change in input prices of 1.5 percent. That will be measured generally by the MEI that we spoke of a moment ago.

It also anticipates a decrease in enrollment in the traditional Medicare program of 0.6 percent, and growth in real GDP per capita of 1.9 and a change due to law and regulations. Nothing is known at this point about that. It could be that Congress would act later on this year, and might include something in the benefit package that would have an effect here. But for now, that's estimated at zero. For a total here of 2.8 percent.

In looking at this estimate for the SGR for next year, we would call your attention to the decrease in enrollment in the traditional Medicare program. To put that number in prospective, realize that we're anticipating an increase in enrollment overall in the Medicare program of about 1 percent. That would be the total that includes the

traditional Medicare program as well as Medicare+Choice.

So to see a decrease in enrollment in the traditional Medicare program, that means we're talking about an increase in enrollment in Medicare+Choice. Given that over 80 percent of beneficiaries are in the traditional program, to get this kind of a decrease, we're talking about an increase in Medicare+Choice enrollment of 9 percent or so. And so the question would be whether or not we can expect that to happen.

Recent experience suggests that maybe it will not happen. The year-to-date through the first of March of this year, we saw an increase in Medicare+Choice enrollment of just under 3 percent. So given that disparity, we have a draft recommendation for your consideration which would be that we would ask that HCFA consider not just the most recent data available on changes in enrollment, but also some reconsideration of the methods that are being used to project enrollment in the traditional Medicare program.

DR. NEWHOUSE: Questions? Kevin, can you refresh my memory on what, if any, statutory authority is to make error corrections? I mean, if HCFA forecasts X enrollment growth and it turns out to be Y, what happens?

DR. HAYES: Yes. If you recall, the Commission

made a recommendation along that line and the BBRA requires HCFA now to go back and correct estimates that are included in the SGR. So in this case, if it's determined subsequently that enrollment in Medicare+Choice was not as strong as had been estimated, then there would be an opportunity to go back and correct that estimate.

DR. LONG: Is that just a going forward provision or was there a lookback?

DR. HAYES: There's a lookback and I believe that the first estimate, the first SGR that is subject to revision is the SGR for fiscal year 2000.

MR. SHEA: Do you recall what the change in Medicare+Choice enrollment was last year?

DR. HAYES: The enrollment change that was included in the Commission's March 2000 report for '99 was 5 percent.

MR. MacBAIN: A couple questions. One is, how does the 2.8 percent SGR translate into the 0.5 percent upgrade adjustment? I thought you said those two were related.

DR. HAYES: What you need to do is to compare that 2.8 percent increase with expected growth in actual spending, and there's a difference of a few percentage

points partly due to -- it's a combination of things. But a big factor here is the increase in the update for 2000 of 5.5 percent.

MR. MacBAIN: So the fact that the SGR of 2.8 is below maybe 3.3 is a 0.5 percent difference, something like that?

DR. HAYES: Yes.

MR. MacBAIN: Secondly, on the recommendation, do we have enough information to be a little stronger than this, of what we think the number ought to be?

DR. HAYES: We had some discussion in the March 2000 report about the potential effects of the BBRA on growth in Medicare+Choice enrollment. The thought was that things like some modest increases in payments to the plans, extension of cost contracts, and this kind of thing might lead to some growth in Medicare+Choice enrollment, but it was just too early to tell.

My read of the situation was that it was just kind of too early to tell, so I don't know.

MR. MacBAIN: Should we at least recommend that the Secretary survey the Medicare+Choice contractors, to get a sense of what they expect? There seems to me sort of a black box right now. It can kind of be whatever the

Secretary wants it to be. It holds physicians responsible for something totally outside their control.

DR. LEWERS: I'd like to thank Kevin for what he has done in this chapter and what he has pointed out. The AMA center that has taken a look at this as well has questioned this 9.6 percent and have given some numbers that are rather startling. Maybe I'll just read briefly, Joe, if it's all right with you, for the record.

That is, if you take a look in January of '99, enrollment fell by 155,000. Then it picked up 110,000 in February, and by March was back where it is. But in January of 2000, enrollment fell by 157,000, grew 23,000 in February, and is 115,000 in the hole in April.

DR. NEWHOUSE: January presumably is the plan pull-outs.

DR. LEWERS: That's part of it, but you have to take that into account. But to meet the 9.6 projection that they're putting forth this year, their average monthly enrollment will need to increase by 186,000 in the next eight months. And it's never done that before.

We see these estimates coming out in the face of numbers like this, this is the third year in a row that they've done this same thing. And I really thank Kevin for

bringing it out. It's just -- I'll give you this, you may have it. I don't know whether they sent it to you or not.

But it just doesn't make sense to me how these estimates are coming about. I'm very pleased with the fact that they've gone from the 2.1 to 5.8 or something on the SGR, that's appropriate. But it just never ceases to amaze me that we end up with estimates year after year after year in the face of very direct information.

DR. NEWHOUSE: Ted, did you want any change in the wording of the draft recommendation?

DR. LEWERS: I think that what Bill has added is appropriate. I think that Kevin's point, if we could predict something that would be very nice. But I don't know, Kevin, you'll have to tell us whether we can do that or not? Or whether we have a number that we would think would be more appropriate from the data that we have. I just don't know, Joe.

DR. NEWHOUSE: I sense the answer is we don't have our own number here, so that this is where we're at.

DR. LEWERS: I can't answer. Kevin would have to tell me whether he has enough to do that. If he did, it would be awfully nice.

DR. HAYES: The only additional bit of background

I can provide is this is the kind of projection that is provided by the actuaries at HCFA. It's part of their work generating what's known as the trustees' report. This is the report that looks at the financial solvency, I think is the word, of the Part B trust fund, and they're doing projections out over a period of years and have some pretty complex methods for doing so.

I'd be reluctant to recommend that we try and replicate that work.

DR. NEWHOUSE: But are the methods explained or is this just actuarial judgment?

DR. HAYES: The methods are not explained, not in detail in the trustees' report or with the materials that are provided. In talking with staff in the office of the actuary it looks like they have some long term projections for what's going to happen with respect to both the traditional Medicare enrollment and management care enrollment, and these projections are part of that series.

DR. NEWHOUSE: I'm wondering if we want some kind of language about explain the methods, as opposed to the Secretary should review.

DR. LEWERS: I would support that. And I won't repeat my comment of the last two years on the actuaries in

HCFA, but they're in the record.

MR. MacBAIN: This essentially is based on a sales forecast for the Medicare+Choice plans, and I think it's a long-standing adage that you don't have your sales force set your premiums, you don't have your actuaries do your sales forecast.

MS. ROSENBLATT: Since everyone is poking fun at actuaries, I just have to say something here. I do believe that it's tied to the long-range projections. There is going to be a group that's going to look at the methods involved in the long-range projections.

DR. NEWHOUSE: But this is just forecasting a year ahead, as I understand it. This isn't the long-range.

MS. ROSENBLATT: So I do think this is a very good recommendation. I'm glad you know about actuarial judgment.

DR. KEMPER: I thought you were going to say it's better than economists judgment.

DR. NEWHOUSE: She didn't have to add that.

DR. LEWERS: It goes without saying.

DR. KEMPER: I just wonder if we should leave the recommendation like this, but if there are recent numbers that would sort of give one pause about the estimates, that it might be useful to include those numbers in the text and

just make it clear.

DR. HAYES: So my impressions are then that we would maybe add something to this recommendation about not only review of the data and methods used to project the changes in enrollment, but also a release of a discussion or an explanation of the methods used to generate them. Is that it? That sounds good.

DR. NEWHOUSE: Yes.

DR. WILENSKY: Further comment?

DR. LOOP: Don't you want to make that a second recommendation?

DR. NEWHOUSE: I think it's within this framework.

DR. LEWERS: That's an awful long recommendation.

DR. WILENSKY: Yes, it makes for an awfully long recommendation. I think we actually have a chance of getting people to read it if they're shorter recommendations.

DR. NEWHOUSE: Kevin, I had one minor question. Why is the MEI estimated increase different from the change in input price estimated increase? 1.7 percent against 1.5 percent?

DR. HAYES: Both of them are for the same time period. I believe that the explanation for this is that the

change in the lower percentage, the one that's in Table 5.2 of your materials is a weighted average of the MEI and the projected change in another category of services which is considered for this purpose, which is laboratory services, which would have -- I think by law -- no increase next year. Does that sound right?

VOICE: Yes, it's a weighted average of 89 percent of the Medicare Economic Index and 11 percent of the lab update, which is zero by law.

DR. HAYES: Thank you, Mark.

DR. WILENSKY: Thank you. Jen?

MS. JENSON: Good morning. I guess before I proceed to discuss the points I wanted to raise this morning, I wanted to give a preview of what I'm going to talk about this morning. I'm first going to talk briefly about the general approach in the paper, the draft chapter that you have. And that's mostly for the benefit of our guests here this morning, who didn't have the opportunity to read the draft chapter.

I'm then going to proceed to discuss three key assumptions I made that underlie the way the paper is set up, follow that up with a discussion of two possible things you might want to consider in suggesting revisions to the

paper, and then finally I'll ask for your guidance in how I should follow up to revise the paper.

Briefly, the general approach of the paper is to begin by asserting that the Medicare program has two key goals and that those goals are to improve beneficiaries' health and to protect beneficiaries from health care costs. Largely based on those two goals, I proceed to raise some questions with the idea of facilitation thinking about whether specific policy changes or reform options are likely to help achieve policy goals.

For the benefit of people who didn't read the paper, some of those questions include does the program pay for things that will improve beneficiaries' health and well being? What should be Medicare's role in approaching healthy aging more broadly? Does the program pay in such a way as to encourage the provision of quality care? Do payment methods account for differences in the markets in which beneficiaries receive care? How much should beneficiaries pay for the care they receive? Does the program structure provide for overall spending control? And what should be the relative roles of public and private entities in administering the Medicare program?

Moving on to the key assumptions, one key

assumption that I made is that a policy goal of the Medicare program is to improve beneficiaries' health. I think it would be safe to say that I got the most comments in this particular assumption. Several people said to me that they really didn't think that the goal of the Medicare program was to improve beneficiaries' health.

I'd like to think that they don't disagree with me, but rather than they're not used to hearing this goal stated in quite this way. I think it's more common to present discussions of this topic in terms of ensuring access to care and monitoring quality. I guess I made the assumption that we want to ensure access to care because we want beneficiaries to get the care they need, and when they get the care they need, that will actually improve their health.

Similarly, I made the assumption that we monitor quality of care because we want to ensure that the care actually does something to improve beneficiaries' health and well being.

DR. WILENSKY: Since you've made a point of this could I just ask you a question? It seems to me that to say what you just now said is very different from saying the goal of the program explicitly is to improve seniors health.

I just wanted to ask whether, as you stated the second sequence, it's that the goal of the program is to provide seniors with access to high quality care because there is a presumption that by allowing that and providing some financial protection, we will indeed favorably impact the health care of the elderly.

But I would suggest that if you think that's a goal, that's very different from saying the goal of the program is to improve the elderly's care. I'd say well, we just make it illegal to sell cigarettes to anybody that's over the age of 65 or make some other very strong public health statements if we truly wanted to improve health, that might do something very differently.

I'm surprised because when you started off you made it somewhat flippantly whether or not this was a goal. But it strikes me that you just made what I would regard as a very important distinction. And I didn't know whether you regarded that as an important distinction or not in your presentation.

MS. JENSON: I think that we mostly agree. I like to think about the access and quality as means and the health being the ends.

DR. WILENSKY: We can have this as a discussion.

I only raise this now because you said one said and then proceeded to something else, and I just didn't know whether you felt that these were synonymous or equivalent statements. I would say that I do not regard these as synonymous or equivalent, really depends on do you think the goal is as you said initially? Or do you think the goal is as you just went through this second version, which is the more common way of looking at it?

MS. JENSON: Personally, I think the goal is as I said it initially, and I think the reason why people care about access and quality is because they care about the ultimate goal, improving beneficiaries' health.

DR. WILENSKY: We can have this discussion afterward.

MS. JENSON: I expected commentary on this particular point of view. I mean, it does reflect the way I view the world, I recognize that.

DR. ROWE: I agree very much with what you're saying and I think we're all saying the same thing, but in order to protect us and you from criticism that this is our personalized view of the Medicare program's goal, it might be that in the enacting legislation there is some language that could be quoted up front about the Medicare program's

goal. In fact, I think there is.

And I think your interpretation of the goals, which I certain ascribe to, is consistent I believe with the enacting legislation. But if we tied it to the enacting legislation, so that people don't get into a discussion about well, that's Jen's view of it, that's not what it's about, which some people might say depending on how you state it, because I think you did state it two different ways.

And the other thing I would say about this is one way I find helpful to make this distinction is to say what it's not, which is just a health insurance program. Many people view Medicare as just a health insurance program. A lot of the discussions we are having in these meetings go far beyond that. They talk about benefits to maintain access and quality and other things.

So if you put it that way, say it's not just a health insurance program, we're concerned about, et cetera, I think that may also help to distinguish it in some people's minds.

DR. WILENSKY: I think the problem is this is a very serious difficult discussion that is actually not given the kind of serious attention in the paper of what would it

mean to set up? Do you view this as primarily a health insurance program? Primarily as a program to promote or achieve good health? And where are we or what can we glean, not only from the words that were crafted in 1965, we're already in the 21st century, but from what indications are that Congress is thinking about as it struggles with it.

This issue, and the reason I wanted to stop you is you, within a five minute time, had seemed to me cover what goes to the heart of a lot of debate about what reform should be all about, what Medicare should be all about, and I think is not something that you can just pass over lightly.

MS. JENSON: One of the things that I planned later in the discussion is to talk about one of the possibilities for revising the paper. And I think it gets at this issue in a way that might be helpful.

DR. WILENSKY: Okay, why don't you proceed.

MS. JENSON: So the second assertion that I made was that the program was about protecting beneficiaries from health care costs. This has caused me less trouble, however I wanted to be explicit about a couple of things I was thinking when I said that, because that affects the way that I approached the paper.

I assume that the Medicare program is not just an income support program, that at least so far policymakers haven't decided to give beneficiaries cash equal to maybe the actuarial value of the benefits they receive that they could spend as the please. Instead, in the current program, Medicare pays for health care services, they cover the costs for services that beneficiaries have received or costs that have already been incurred. That wasn't very clear.

So Medicare pays for health care costs for services that beneficiaries have used. Program policies such as those regarding coverage and payment and quality monitoring, I think are in part also about ensuring that Medicare is paying for necessary health care costs.

Now we could move to a different model, perhaps a model where the government provides money to beneficiaries to buy a health insurance policy, so it's not paying for the health care services as directly, it's giving the money to pay for health insurance. But I think that a similar thing would be true, that the beneficiaries would be expected to spend that money on health insurance, and that they wouldn't be able to use it for other things.

DR. WILENSKY: On that, I don't think you mean that exactly as it's written. It's not to make health care

zero cost. That's what that says. You really don't mean that. You mean something about it should protect seniors from excessive costs, unreasonable costs, extraordinary costs. But you don't mean it as it's -- I don't believe you mean that.

MS. JENSON: No. Like in some cases, just imagine I have homeowners insurance and there was a fire in my home. The insurer might just give me money and I could use that money to buy a new suit or make repairs.

DR. WILENSKY: That's a different issue. I think we all agree that this is not an income support program. But I'm questioning more the statement. You say the goal is to protect seniors from health care costs, but you don't mean that.

MS. JENSON: Not all health care costs.

DR. WILENSKY: That's my point.

DR. ROWE: To lessen the burden.

DR. WILENSKY: Yes.

MS. JENSON: We definitely agree about that.

DR. ROWE: I think the actual out-of-pocket expenses are greater than they were X years ago.

MS. JENSON: The third key assumption is that our goals wouldn't change in a reform program. So the goals of

protecting beneficiaries from health care costs, or of improving beneficiaries' health are goals that we have for traditional Medicare. They're goals that we have in Medicare+Choice. And I believe that they're also goals that we would have in a reform program.

Given that I assume that we'd have the same goals, you'd ask the same questions to help evaluate whether or not policies are effective. Certainly policymakers would weight these goals differently and they would prefer different policy approaches based on how they weight the goals.

For example, policymakers might adopt a health insurance model that's relatively indifferent about specific health care goals. Or they could have specific coverage or quality requirements that imply that they're more concerned about achieving specific health aims. The approach that policymakers take is just a function of their preferences.

Finally, I assume that policymakers can achieve their goals in different ways. The Congress could specify requirements to help achieve certain insurance goals, certain health goals, or they could allow private organizations to make those same decisions.

Addressing, I think, two possible approaches that you might want to consider for revising the paper, one is

basically to expand its focus, and one would be to change its focus. Taking on the latter item first, this paper focuses on policy goals, the two goals that we've discussed already, and then discusses policy tools in the context of those goals.

For example, the section on limiting beneficiaries' financial liability, which would be a goal, discusses some specific tools like premiums and cost sharing. Another example would be that the section on providing overall spending control, which is a goal, as part of that discussion has examples on the sustainable growth rate system and on defined contribution approaches, specific tools that you might use to help achieve those goals.

Arguably, you could have organized the paper the opposite way. This is kind of an issue of a multidimensional problem and figuring out where to start, could have instead focused on the tools and then discussed what goals those tools do or no do not accomplish. If you were to change the paper to take that approach, it would make the discussion of the tools more prominent, but it would make the discussion of what we're trying to achieve through reform and through the Medicare program less prominent. That's just a choice.

The other possible approach would be to expand the focus of the paper somewhat. Right now the focus is primarily on Medicare's role as a health insurance and Medicare's role as a health program. You could step back a little further yet and discuss in more detail Medicare's role as a social insurance program.

The paper discusses some social insurance features of Medicare as part of the discussion about limiting beneficiaries' financial liability and ensuring program solvency, but you could take the social insurance issue on more directly.

If you chose to do that, questions we might want to raise would be what should be the role of current workers and tax payers in subsidizing care for the elderly and disabled? Or what responsibility should individuals have to save for their future, to protect themselves from financial costs associated with receiving health care services?

The first draft didn't directly tackle these issues, quite frankly because I wasn't sure that you would want to. However, to make the paper more complete, the Commission might want to raise those questions, even if they didn't answer them.

Finally, I guess I'd want your feedback on how to

follow up. We can begin with a structure of the chapter as it is right now and work on tightening arguments, fleshing out details, changing tone where that might be appropriate. Or we could make larger changes to the approach the chapter takes.

DR. MYERS: I'd like to suggest that we consider a different approach. Yes, the goal of the Medicare program is to improve beneficiaries' health. But there are two huge components of that that we don't separate. One is the prevention of disease or maintenance of good health. The other is the treatment of disease when it occurs. And I don't think we're emphasizing in any way in this paper, that I can see, that first component.

In my view, one of the major assets this country has created in the Medicare program is the opportunity to help our senior citizens avoid disease, avoid needing treatment, avoid hospitalization. And we are just not taking advantage of those opportunities.

I really would like to hear from my colleagues on whether or not you agree that that has to be a huge emphasis in looking at this framework. I'm not sure whether that was something that was implicit within your comments regarding health, but if it was I would like to separate it out and

really focus in no it, because it's a major important issue.

MS. ROSENBLATT: I think when we discussed this chapter last time we all had a lot of concerns about would we be able to do the subject justice. I guess my reading and the discussion so far this morning has indicated to me that we need a lot of time to discuss these issues as commissioners. I think there's a lot of personal disagreement on what we've already talked about that I, for one, do not think the goal of the program is to improve health. I think it is to make access. I think it is an insurance program.

So I personally disagree with a lot of the comments that have already been made this morning. And I think to do it justice we need hours of discussion on that.

So my recommendation would be sweeping reform of the chapter. Don't even consider it for June. We probably need the two full days of the retreat plus more time than that.

DR. WILENSKY: Alice, let me just break in and try to get this issue off the table. To my view, this paper is not ready for prime time. It's not close. These are not editorial changes. It's a very difficult issue.

What is it we're trying to do? What did people

think they were doing in the beginning? They certainly set up a program that looked like an insurance program. Maybe in the back of their mind they had improving health. If we want to mature or change the focus because of what we now know, what we now think we can do, what would that suggest for -- I mean, these are very big issues.

So when I read this, my immediate take was whether or not the Commissioners can ever come to agreement about what such a paper would look like, I don't know. But I think just to relieve any anxiety that some of you may feel, let's decide this is not a June report. This is not doing a few edits and we'll have it out.

So having said that, I think it may be useful to continue with this discussion, but rather than have people feel like they have to make their point, I don't think that's an issue. If there's any disagreement, I don't usually want to be quite so sweeping on it. But the kinds of by the by comments we've had this far indicate this is not a small rewrite and we'll send it out.

MR. SHEA: I think this merits substantial time and discussion so I'm not in disagreement there. But if we don't do it this June are we going to be out of the loop timing-wise here, in terms of helpfulness to our

Congressional customers?

DR. WILENSKY: I think that's a legitimate question but I think the answer is not because of this. Where we can be helpful with the committees is to provide them with some technical assistance as they struggle with these issues by trying to clarify some things are insurance issues, some things are health promotion or disease prevention issues, to give them technical assistance on any questions they raise about the administration prescription drug issues, about actuarial equivalence issues, about whatever they ask us to do.

But this is something where it is what is going to be guiding individual members correctly or incorrectly as they try to go forward. And I honestly don't believe our attempt to come to a collective position is going to change their posturing of where they're coming from and where they want to go to.

So I think there are things we are going to have to be very careful of, try to be helpful as they struggle through the summer deliberations, spring and summer deliberations. But this kind of philosophical underpinning, they'll more likely approach various of us as individuals, your organization as a group, to try to help guide them

about what is ultimately what they're trying to do. I think that it's probably okay.

But in any case, I think we have no choice. Even with the context, there were a lot of blanks to be filled in that are very important blanks to be filled in, in terms of more discussion to come later that we sought. But that's only the tip of the iceberg. The real question is that these very difficult issues of is this an insurance program? Is this fundamentally frontally a health program? What would it suggest in the redesign? Is that really where people want to go?

I just don't see that we can get it done.

MR. SHEA: Thinking back to the point that Bill raised yesterday about reformatting our work products here, I wonder if this might not be a candidate for not a March or June report, but some other kind of --

DR. WILENSKY: Absolutely. If we can ever get ourselves together in agreement I think could potentially be a nice fall-winter stand-alone chapter. Whatever happens or doesn't happen in the next several months, I feel quite confident that more will be yet to come. So if we can in fact, as a commission, come to some agreement, and the fact that we may have a slightly different mix of people isn't

going to make it any easier. Some acculturation as to here's all the stuff we've been struggling with is going to have to go on.

But I think it would be very definitely a potential stand-alone chapter in the fall or winter of 2000. I just want to respond to relieve that.

MS. JENSON: Could I ask one question? As you think about what the different goals of the Medicare program may or may not be to different people, I was wondering if it would be helpful to list perhaps even a longer set of potential goals and to make it clear that different people have different goals for the program? I agree that it would be difficult to reach consensus.

Actually, I did take pretty seriously the idea that different people weight the goals differently and it's going to affect the types of proposals they suggest.

DR. WILENSKY: My personal opinion is having a laundry list of goals wouldn't clarify it. This issue was started early on, is this fundamentally a program to protect and improve health? Is this an access and insurance program to provide economic security? And with the implicit or explicit assumption that in doing so we will also be aiding in the health and well-being of individuals -- I mean,

there's a whole lot you can write about, how to struggle with this, and where it leads you different directions, and blah, blah, blah.

And even looking at the language in the beginning isn't really going to clarify. You can see whatever these guys put in print and then say oh yeah, but by the way, they set up a Blue Cross Blue Shield program a la 1965.

So the fact that you can have some lofty goal pulled out of either the Congressional Record or the statutory language is not going to end this issue. I mean, this is something that maybe we could shed some useful discussion on and the kind of policy directions it takes you, but it's just one of a number of issues.

I just wanted to get people not to be nervous that this was an issue of we're going to put out the final chapter after a few revisions on it.

DR. NEWHOUSE: Gail, I don't know if you've given any thought to how we can best use the hour or so we're going to spend here discussing the chapter, because I have some substantive comments. But I also had a process comment, which is what we thought our principal audience was for this paper, and in particular what we thought the reader we were trying to reach knew about the Medicare program and

what they cared about.

Were we writing this for Congressional staff?

DR. WILENSKY: Congress and staff.

DR. NEWHOUSE: Congress and staff?

DR. WILENSKY: That's normally who we -- I mean, we like to make it generally more readable, but I assumed it was to the people we usually address ourselves to.

DR. NEWHOUSE: I understand why one would reach that, but it also looked to me like this might be aiming at a broader audience, which would affect how it was written. It might be, for example, written to -- one might use it in a course for people that would be future Congressional staff.

In any event, what we assume the reader already knows is important, in trying to figure out how to write this chapter. I mean, of course what the questions are that we're trying to shed light on for them. On one level that's pretty clear. I don't know if we want to talk about that, or if we say well, it's Congressional staff. Is this committee staff, personal staff, all staff?

DR. WILENSKY: When we write we are not only writing to those who devote a very large amount of their time to health care issues. At the very least, when we do

our papers and we are addressing Congressional staff and members of Congress, the fact of the matter is most members of Congress, most Congressional staff, do not focus on health care in general and do not focus on Medicare in particular.

So if you just, even at that level, say that this has to be a document that is addressed to people who may be in decision making positions but who aren't experts in this area about any of this.

DR. NEWHOUSE: That begins to get what I'm getting at. Our standard reports assume a hell of a lot of knowledge about the Medicare program. I think, for this purpose, we don't want to assume all that.

DR. WAKEFIELD: Gail, now I'm not sure I want to make my comments. I was going to direct them to some substantive areas. They're a little bit more microlevel.

But it seems to me what might be useful is a sense of direction. Are we, as a group, going to have a discussion around some of these fundamental issues first, and then go back with some direction for the staff? Is that the sequence now?

DR. WILENSKY: Let me make a suggestion of one way we might want to proceed. I've given Murray my copy, where

I had a lot of comments sometimes about reaching the things late in the chapter, of saying this is a fundamental issue, this needs to start it.

To the extent we have more big picture issues that we want to talk about, I think we ought to just raise them, these are issues. We're not going to solve this here and now, and it might be helpful to give back responses. To have this discussion, to let it go and let everyone have a say about where they are on this issue, to give back comments to Jen and to try to have some time in our July retreat to talk about this, to see whether or not we -- and we also give people a little more time to think about the issues that we are just bringing up now.

I'm thinking about Medicare insurance program, with all of the indications about why would want to have an insurance program for this. Medicare as a disease prevention and health promotion and care of sick people when they get sick program. To think about the various issues that have already been raised, and it may be in the context of this paper. And come back and talk some more, there may be some other ideas that Jen wants to think about, and to have this discussion in July.

Are we likely to be able to come to a way of

thinking about this that might be helpful? I don't know what the answer is. But I am quite convinced we're not there yet, and it may be we just need to have some of this discussion now.

MS. JENSON: Gail, actually I appreciate everybody's comments, and people had warned me that I would provoke the reaction by writing the paper as I did. And I actually think it's helpful to just get out there and say something so that you have something specific to react to.

And to the extent that you can give me a little bit of structure, I can have a new paper for you at the July retreat that gives people something specific to respond to.

DR. WILENSKY: You can go ahead and do that if you want. I think you may be underestimating the difficulty of this task. To the extent people have either written comments, they should give them to you and to Murray. We ought to continue around this discussion and let people say what they have to say. You can try to go back and think about how to synthesize these issues, and you're welcome to give it another crack and see whether you can get there.

I think this is harder than you think. But to the extent that we can provide not the answers to these questions, which you've wisely not tried to do, but to ask

the questions in the right order and in the right hierarchy, which I don't think you've actually done yet. That would be very helpful. And to talk about the ramifications of what taking one path versus another would suggest, relative to where we've been historically or where we seem to be going, would also be helpful.

But we may have some absolutely fundamental disagreements that will mean we're going to diverge in different paths very early on. We can lay this out, I don't know how helpful that chapter will be or not.

But I don't want to discourage you from taking another crack, given what you hear today and what people either have written on their chapters or that they may want to call and share with you.

DR. WAKEFIELD: Can I just finish then? I'll go ahead and give you the comments that I have, but frankly they do relate to some of these bigger issues. And how this gets cut is going to impact even what my comments are, because fundamentally they relate to how one views access, equity, et cetera, et cetera.

So until we've had that bigger discussion, I'll give you these comments. They may or may not be relevant depending on what the final views are of the group.

DR. ROWE: I think this is a very interesting discussion. I agree with you that we're not ready for prime time. I associate myself with the remarks of my colleague, Dr. Myers.

My advice to you, Jen, would be that you come back with a document which basically examines the question of whether Medicare is a health program versus a health insurance program, what the implications are of going one way versus the other. Maybe Alice is right, it's a health insurance program. That's going to have an impact on our schedule, because the meetings will be shorter. We won't have to discuss access. We won't have to discuss quality assurance.

MS. ROSENBLATT: That's making an assumption about what insurance is about. I strongly object to that.

DR. ROWE: All right, I accept that, Alice. I'm just provoking you a little bit.

What do we mean by just a health insurance program? Let me just give you one example. If we're a health insurance program, which I'm happy to describe it as if you wish, and we're the guardians of the trust fund, and we've got these patients for the rest of their lives, then it's in our best interest to decrease utilization, right?

So we're going to keep giving flu shots. We're not going to stop giving flu shots, because that's cheaper than paying for somebody who's in a hospital with influenza pneumonia.

Being a health insurance program is not inconsistent with wanting to decrease health care service utilization and therefore, i.e., having people be healthier. So I think we just have to have a discussion about what would it mean if this is the way we look at it? What would it mean if that way? What are the pros and cons? What's the taxonomy?

And if we can come to some consensus with respect to that, then the rest gets easier. And I think it would be very helpful. The prescription drug benefit issue falls out one way or another. A whole bunch of things fall out.

So with respect to that, I would forget the social insurance piece. I would just do the health insurance versus healthiness, healthy aging piece.

The other thing is, just to give you some positive feedback, one of the things that hasn't been mentioned which I think is clear here, which I think is appropriate and which I would be very supportive of, is your focus throughout this, from the first word, is on the beneficiary, rather than on the providers and/or the trust fund or

whatever. All those things are relevant, but your focus has been on the beneficiary and I think that's the appropriate focus.

You can get into all the other issues, but that should be the focus of the discussion.

MR. MacBAIN: First in defense of Jack, I think if Wellpoint had a larger presence in New York, he would have a much more favorable view of insurance.

I'm not sure how fruitful it is to talk in terms of an insurance access program versus health promotion, health improvement program. I think there are different ways of looking at things. I tend to think of them as two different sets of axes or different frames of reference.

For me it would be helpful to look at the various approaches to reforms that have been put forward, at least described generically if not in terms of specific bills and sort of plot where they are on each of these two sets of axes. So we get a sense of how does it work as an insurance and access program? But then also how does it work in terms of prevention and health promotion, improving beneficiary health care?

I think they're really different things. The program started out, as I recall the debates, with the

implicit assumption if you can simply get people into the health care system, the health care system will take care of health promotion, disease prevention, all that stuff. All we want to do is keep the costs of health care from impoverishing seniors and their families and make sure that lack of funds doesn't prevent access to the system.

Now we've got a more sophisticated view of the health care system and we're saying it's also important to us what happens once you get in there.

But I think they're really different questions and they're not in opposition to one another, but rather they're both important sets of questions to ask about any of these proposals. If something seems to do a lot of interesting stuff, in terms of health promotion or disease prevention, but fails on the access measures, then it's not going to work. That's as much a concern as we're more wont to express the other way. Well, it's great if you've got access, but is it access to something you'd want to use?

So I would suggest trying to go through and sort of benching up all of these different proposals on these two different frames of reference, and treat them as different from pieces of it.

Also, I would like to encourage that even at the

draft level this be edited very carefully to make sure that we don't either have any inadvertent or apparent emphasis on one particular proposal. I caught that as I was reading through. I think it just had to do with the way things were worded, that we want to be very careful not to have anything sound like an endorsement on the part of the Commission of one particular approach. At least I don't think that's what we want to do. My sense is we want to simply say these are a number of different avenues that have been proposed and here's what happens, here's what we think happens from an analytical standpoint, if you take any of these avenues.

And third, I really think we need to answer Joe's question a little more carefully, about who's the audience. As I read through this draft it seemed to me to be pitched a little too elementary, to interest the policymaker, Congressional audience. I do think it's helpful, if we have a broader audience in mind, maybe to have an introduction that sort of lays the framework for here's what Medicare is anyway.

But I think if it's pitched at too low a level, we're going to lose the audience that really could find this useful.

MS. NEWPORT: I agree with a lot of what has been

said already but maybe a little amplification on approach. I was concerned about the audience. Who are we reaching to? And I did agree with Bill that the tone was a little too elementary, given the type of things that we do now, the type of rigor we bring to the discussion.

So as I was thinking about this is how do we frame the balance between what are the ways to look at it, identify problems, identify process issues and process improvements. Sometimes on the Hill something that really is intended to be wholesale reform can be destructive to already good processes. This is inadvertent consequences to things, and I think that are unintended. Sometimes it's inadvertent.

I think that if we bring our institutional expertise to the table and define this as much a guide to the policy folks, we've done research on this in the past. I don't want to devolve into sort of a literature search, but having done something like this in the past, this was the results, this is what our research has shown.

If we can inject some cautionary experience, that would be helpful to them. I think as folks, new health staff, people that haven't been around as long as some of us, I think we should try to create some guideposts,

framework for looking at near term process improvement, what really would be wholesale reform, and then some definitional ways to think about.

We have evolved into kind of a mixed framework where there are insurers but there are health plans and Medicare+Choice and providers, that clearly look at this as delivery of health care.

So I think philosophically the building -- and I was real comfortable with the model that the prescription drug chapter uses, which is kind of a historical model built up to things to think about. And I think that without creating a specific position, created the ground upon which the analysis should be spread.

It's kind of a balance but also then pointing people to work that's been done previously, because I think in the rush to get something done, we've all experienced this one way or the other, we don't necessarily have a good resource for saying oh, wait a minute, they did that already, or understood what was done.

Now having said all that, and just taking this paper into five books basically, I think that if we could try to conceptualize that a little bit, in terms of pointing to previous evolutionary results, then that might be

helpful. And then we can establish the right tone and have a document that is useful and to a level that maybe brings a little more sophistication to the table.

If we can raise the dialogue higher, I'm all for that.

DR. KEMPER: This is clearly thought-provoking and I found it that. I guess my first question is, what are we trying to do? What are we trying to write here? And I guess my reaction to what it came across as to me was somewhat overwhelming, and perhaps this is an occupational hazard teaching health policy, but I thought this is the beginning of a health policy textbook, that's going to encompass everything. It's very all-encompassing.

I guess it seems to me we have a choice of two quite different things. One is a statement of stepping back, how does the Commission view the Medicare program, its goals, and how to go about it, health versus insurance, and a whole other set of things, which starts with the beneficiary and so on.

A second, and I think different kind of document, would be one that talks about Medicare reform and Medicare reform proposals. And to me that would start at a somewhat different point, as what's the origin of those, what's the

philosophy of those. It would be much more cost focused, private versus public sector focused, at least in the current dialogue because those come from a different direction. So I think they're sort of a first cut of what are we trying to do here.

I guess that's something that I think merits discussion at the retreat.

My second comment, and I think this is also a retreat topic, is how do we think we can best weigh in to be helpful on the Medicare reform debate? Is it at one extreme talking about values and principles of reform and what the goals are? Or is it, at the other extreme -- and I also thought about the Medicare drug benefit chapter, where you get down to take a particular aspect of reform that's particularly important and get down to some very specific issues that would have to be addressed.

And there are two very different ways of trying to weigh in. Whether we want to try to weigh in and how seems to me a big issue.

So those are my reactions, but I did find it thought provoking.

DR. LEWERS: I generally agree with what has been said. I think there's one area and it goes back to

insurance, non-insurance, it goes back to Joe, who are we addressing. But when I look at the word reform and then I began to think about the problems, the basic reform, which I think has been slighted, even though you have a section on it, is the financing of the program. You talk about the financing and yet you talk about that as an issue driving reform.

It is driving reform but the solution of it is a major -- no matter where you are in a program, whatever you define it, you've somehow got to address that. And I think you've left out a lot of the major issues that are driving why we've got a financial program.

We can change all the benefits we want, but until we address that issue, and that's what has failed to be addressed in virtually all the groups that have taken a look at it. They've mentioned it, but nobody has tried to address it. I don't know whether we can or you can.

But at this point, I think that needs beefing up tremendously in this point.

MS. RAPHAEL: I tend to agree with what Peter said earlier. I think we need to have greater clarity as to the audience and the value that we can add to this whole subject. I personally do not believe it's very fruitful to

spend time on the goals, health insurance versus health program. My employees have a health insurance program but I give them flu shots. I want them to be healthy and I will do certain things that will keep them healthy and working and productive.

So it's not an either/or kind of situation. To me, it's just someplace along the spectrum.

I do believe that a lot of the issues have to do with the fact that it's now 35 years or so since the inception of the program and the world has changed. I mean, I think that not only have we a changed demographic situation, we have a changed health care system. The things that are high cost now and available were not high cost and available then. People's expectations are different.

The experience we've had in government with entitlement programs is very different. Our notion of individual responsibility and private and public sector roles is different. And I think that really frames what we're trying to deal with in reform.

I think that I personally think we need to kind of rethink how we are framing this chapter, and not start from what are the original goals and are we achieving those goals, but really look at what has happened in this

intervening time, which I think is propelling a lot of what's happening with the reform movement.

DR. WILENSKY: My suggestion is you go back and look at the transcript of what Carol just laid out would be a good series of issues. I think those are the issues that ought to drive this chapter, exactly as they were phrased. I'm sure she couldn't do it again exactly as she did. We ought to go back and make use of the fact that there is a transcript, because I think it did lay out a way to think about the issues in some kind of a hierarchy and not to focus on whatever was in their minds 35 years ago, but to get at these issues nonetheless.

DR. NEWHOUSE: I may be missing something here, so Woody can come back, but I wouldn't have started this with whether the issue is health versus health insurance. To me they only come into conflict really on the issues of coverage of preventive services, and kind of where in the government budgeting scheme of things health promotion efforts go, whether they're in the public health service or the Medicare program.

Those are not, I think, the biggest issues we have. They're issues. And they certainly ought to be here and discussed, but I wouldn't have started with them.

I would have suggested that there's -- I'll come to financing momentarily, but there are at least a couple of very large issues. Or I would have put larger than what we do with preventive services in covering. One is since I think we want to take it as settled that we're not going to have a single government insurance program, we're going to have some kind of competition among a traditional program and health plans or whatever, but there will be multiple choices, how that competition is managed.

What does management mean in managed competition? Who gets to play? What kind of standardization, if any, is imposed on benefits? There's a whole range of issues around managing competition, a very large set of issues I think.

The second large set of issues, I think, goes to in a world where not everybody gets everything possible, who gets what? This bears on patient protection legislation. It comes up obliquely in what you have, and you say does the program pay for the most beneficial medical care. What we have now is the program pays for home health services or physician visits or what have you, or medically necessary visits. It doesn't say for this person it's really beneficial, for that person it isn't.

Implicitly in the managed care plan, the managed

care plan is supposed to try to make some distinctions like that. The traditional plan doesn't, but yet there's a large issue in terms of trying to think about the overall design of the program and who gets what in this program.

On financing, Ted, it's certainly a big issue but there's basically three alternatives. There's general revenues, there's payroll taxes, and there's beneficiary payments. And that's the ultimate, I would say, Congressional call on what mix of those you use. So I certainly don't mind laying out the option, but I don't think we want to tell the Congress how to finance it. We want to lay out options.

But the financing option, relative to things like how do you make competition work for you or work well, or how would you know if it's working well, the alternatives in financing seem reasonably straightforward to me.

DR. LEWERS: I don't disagree, Joe, and I think the only way to tell them how to do it is to be part of Congress, and that's not where we're headed. But the way the structure is set up based on workers per beneficiary, the aging beneficiary, the fact that we're putting this on the back of a certain age group. It depends on who you're directing this chapter to, as you've repeatedly pointed out.

But this financing system, the way we're doing it now on the workers is just not going to work anymore.

DR. NEWHOUSE: I agree.

MR. SHEA: I don't so much disagree with the comments that have been made, as much as I want to say there's a different perspective on this chapter. I agree with Jack's point about there's a real strength, and something I really appreciated was how this was sort of a beneficiary focused discussion, as opposed to the prescription drug chapter, for instance, I thought was a terrific piece of work. I don't know how many volumes it's going to run by the time it's finished, but it was comprehensive. But it was very policy-ish.

And the value to that is in having it look, in simple terms, at broad goals, complex issues, is in the point about well, what are we going to do in the next round of changes here? What is the sort of basic program? And in terms of the other audiences, particularly I think of consumer organizations, beneficiary, AARP, our own constituents unions, thinking about this, to sort of make sense out of the specific debate. This is a valuable kind of piece of work.

That's not a disagreement with a lot of the good

points that have been raised, but I just think there's value here once you sort of look beyond the Congressional customer set, which I agree is our primary audience.

DR. WILENSKY: Let me respond just very briefly to that. I was hearing it's too elementary. With all due respect, my concern, in terms of if we are addressing it to members of Congress and their Congressional staff, is I don't think that this is a question of being too elementary because people are very busy who know there's a Medicare program, know very basic information about a Medicare program.

But if you get beyond the immediate committees of jurisdiction, and even with those who are on a committee of jurisdiction but not on the health subcommittees, these are not people who know the details that we slog in all the time.

So I actually agree that documents that are useful, it may not be that you can have it quite the document you would have it if you were strictly going to the outside of Washington lay public. But the notion of having this not be for the few members of Congress who are totally immersed in the details of Medicare or the very few staffers who know all the details, I mean they are people who we can

try to help think through these issues individually.

But if this is going to be useful, I think it will be for a more general audience. And I didn't regard this as being a problem of too elementary. I had other problems with it, but I didn't regard that that was a problem, personally in terms of what I found.

So what I was hearing was uh-oh, I think people were picking up, and at least taking a different interpretation than I would have, in terms of the pitch and the tone.

DR. LOOP: The only thing I would add to this discussion, it picks up a little bit on Woody's earlier point. That is that, apart from genetics, the single greatest determinant of health care status is education. I'm not impressed that we educate Medicare beneficiaries as well as we could about their prevention and about maintenance of their health.

I think that's something that several agencies could work on and that we should emphasize in the report.

DR. KEMPER: Following up on what Joe said, some of the issues are very real issues in the current Medicare program, like how to manage the competition. And we may want to, in thinking where the contribution could be

greatest -- and incidentally perhaps least controversial -- might be weighing in on things that are relevant, both to the current program or modifications to the current program as well as more fundamental reform issues.

DR. WILENSKY: I don't have a problem with saying that that's an issue we can raise. Judy Lave, in some of her exchange, had talked about big R, little r reform. That's clearly in the little r reform.

You don't have to agree, but I think that's a different level of talking about issues than the other discussions that we've been having today, at least up until now. And it's not a question of not to include them. It's a question of an initial discussion on some of the big reform issues, in terms of what are the goals of the program, et cetera.

I'm not suggesting on this going back to health care program, health insurance, that you make that into the sole focus of the paper. You do tend to look at some different issues, and it's one thing to say, as Floyd just did which I would very much agree with, that we don't tend to devote a lot of attention to providing good education for seniors as consumers of health care; that it is something that a number of departments in the federal government might

want to take on as a serious issue in thinking about what would go on.

That's a sort of different strain from trying to look at this as a way to protect people from the vagaries of major illness in their older age and what that can do to them economically and financially, and the kind of program to protect that, and to talk a little bit about the tensions that exist between these programs, about are you really trying to pay for the routine, expected expenditures? Are you only trying to do that for people for whom they may not really be able to do that?

It raises, at least obliquely, the issue of social insurance. This is something where it strikes me that there are reasons to raise this, particularly when you talk about a program that is trying to be a health care program as opposed to a health insurance program, is which kinds of services do you necessarily need to provide? Do you need to provide them free, low cost, to whom, to all elderly, to some elderly? Is it worked in conjunction with an education program?

As those of us around the table reach 65, and for some of us not so far away, do we really need to have that provided free in order to have us use it? It's not clear to

me that that's the case.

It raises the kinds of questions of, depending on how you're looking at this, what are you really trying to do? And then where does that suggest in terms as it would go forward in some of these reform issues, and in terms of the financing that Ted raised, what I saw looking at your discussion was the presumption of we're staying more or less in the present structure, trust fund wage financed with some supplemental general revenue, and talking about having this issue be driven because the trust fund is going to run out of money.

Well, as it now looks, the economy doesn't go south, that's going to be when the cows come home, more or less. This is now talking way out. So it's not really a trust fund issue.

And the real question is this kind of peculiar financing arrangement that we tripped on in 1965 of wage tax, which most economists believe is one of the worst of all taxes that you could have come up with, and a piece of general fund financing, and a Part A and a Part B. I mean, all of this just begs for reconsideration, not only about how else to do it but then who should do it.

So I think that that issue is a legitimate one,

although ultimately, as Joe pointed out, there are very few choices. But how you get from where we are to a different structure is not so easy, and who you think ought to be paying it.

So it's possible we can get through this, but this is, as I said, not at all an easy chapter. And I suspect it will take many or several iterations. Many of our difficult chapters take two or three iterations. I think this is definitely going to be in that ball game, rather than not.

And at some point we'll have to decide whether we think what we're producing will be helpful to people as they think they're going through Medicare reform. And I think this is basically something to help people as they think about Medicare reform. That's why we're doing it, to try to help them understand the issues they have to deal with, the potential conflicts, the way they may go down one road versus another, the kind of implications that that suggests.

And if we can do that and feel at the end of the day that we've helped people think through this clearer, then we'll have a nice contribution. If it turns out that it's such a large murky issue and that we ourselves, of 17 commissioners, have so many disagreements about the implications or what we think is being suggested, then we

may have to decide this is not worth the issue and any of us who are inclined can write our own version of how we ought to try to frame reform.

I suspect there may have been some people, when Joe made his comment, it's clear we're going to have combined private sector programs and a traditional program. It's a question of how we manage competition. I suspect it's possible that in this room and around this table there are people who might have said excuse me, I don't think that's a given.

So in all of these places --

DR. NEWHOUSE: Multiple programs.

DR. WILENSKY: It may be that we're going to end up either we have only a single program or we have multiple programs. But we can't have a traditional program separate from a set of multiple privates? I don't know what the answer is. Right now it's looking like we're having a big struggle.

But those are the kinds of things where we may or may not be able to say something that's useful. I think if we try it one or two more rounds, either we'll be close to having a document that we think adds something and is worth circulating, or we will decide this is using too much of our

time, given all the other issues, and that we can each do it individually if we're so inclined.

I don't want to tell you to stop. I think this is going to be a hard thing to pull off.

MS. JENSON: Could I ask you a question? Recognizing that the hill is pretty steep and that the likelihood of getting consensus, the probability is not one. I feel like I'm getting a little bit of mixed feedback in terms of if you were to try to reach consensus as a commission and have some sort of reform chapter, whether you would want that chapter to be about goals and what we're trying to accomplish or how we might try to accomplish it?

DR. WILENSKY: No, it has to be more than just goals.

MS. JENSON: So it would be a combination of something about what we're trying to accomplish and --

DR. ROWE: I certainly am hearing that. There is a really important part of this discussion, which I think is very valuable -- triggered by this, which is our consensus view of what the Medicare program is as MedPAC commissioners.

If this were Cardinal Newman this would be apologia probata sua, what are we about, why are we here? I

mean, I think that's useful. But just to do that and stop would be, I think, less than half a loaf. But it provides a context for the reform discussion.

MS. JENSON: I guess if I were to follow up on Joe's comment, and to talk about how a competitive system might work, when you do something like that you're making an assumption right off the bat about what you're trying to accomplish.

DR. WILENSKY: Go back and look at Carol's comments. I really think she rattled off a whole series of issues that, if you follow, will lay out -- I mean, not only the question of goals but some of the questions that we have to ask. And a lot of them are raised in your paper. It's not that you didn't raise them, it's the ordering and the context in which you raised them that troubled me.

I guess what I think you ought to do on this is look at the individual comments you get, look at the transcript of this discussion. I would suggest let's try one more round, either as a full paper or as a detailed outline or outline with some discussion under it, but not necessarily a full-blown paper.

We can have some discussion as to whether we're getting closer in July, and if it seems like we are really

still floundering, make a decision about whether or not it's worth it to invest the kind of time it might take to get to a chapter. Not of agreement, because we're just making sure we ask the right questions and talk about the right implications. We are in no way trying to answer these questions.

But I think it's clear that you're a long way from having laid out the right structure and the right format yet, and you'll just need to go back and look at a comments and look at what we're saying and see if you can get there from here.

DR. BRAUN: It occurs to me when we're talking about Medicare reform that we have not only the seniors to think about but also the disabled, and what implications that has as we're working through the questions.

DR. WILENSKY: And also the future seniors. One of the things is, this is not just a program that is directed toward people who are now disabled or 65. It is primarily a program -- with this whole issue about what this is suggesting for the other people intimately involved in this program because they're paying and expecting it to be there as that near that, I think that is a lot of -- obviously as you've indicated, what is driving it. Not just

the financing but the fact that who's in there now and then this sweep of people who are going to be coming into it.

MR. MacBAIN: That raises an interesting issue. When you look at the history of Medicare starting out as just a program for the elderly and then adding disabled, adding ESRD patients, now talking about adding a buy-in for people 55 to 65, the scalability of any particular reform approach may also be a worthwhile factor.

DR. WILENSKY: I'm not really sure, as I've said, whether in the end we'll have a chapter or not. But I think that by July we may be able to tell whether it's worth additional effort.

DR. WAKEFIELD: Just three quick points. First of all, I know we'll be discussing this more, I want to just weigh in on the issues of access. A lot of this depends on how we come at this, but at least from my perspective right now access is still a big piece of the picture that needs to be discussed.

When I looked at that first goal of improving health I'll tell you that in the back of my mind I was also looking at that from a maintain and improve health perspective. So I was wondering, does improvement encompass maintenance of health or not? So just as a second issue.

Third, some of the issues that swirl around it are reflected in the chapter but it's not hit on maybe as directly as it could be as a concern and that is, we kind of give an overview of some of the significant variation in the amount that Medicare spends per beneficiary but we don't really come at it from an equity perspective. I think it's maybe worth considering, at least again from the beneficiary's perspective, what does it mean with regard to equity when Medicare has the availability for some beneficiaries of pretty substantial coverage for prescription drugs and for others virtually none? Or coverage that has a pretty hefty price tag associated with it?

So those fundamental issues around equity. Not to come up with necessarily solutions, but to identify it as an issue.

Third and last I'd say, from the perspective of an insurance program and its adequacy, maybe to hit a little bit harder the extent to which Medicare does or doesn't pay very well for catastrophic costs, as a focus. So that would be my third in terms of coverage, insurance coverage, to speak a little bit more strongly to that.

Again, we'll be talking about all of these issues,

but those were three that resonated for me when I went through the chapter.

DR. WILENSKY: Jen, why don't you take another round at this and we'll see, we'll assess. I think this is a useful discussion for us to have. It's only a question at some point will we decide that it is taking too much time away from other issues we need to deal with, or does it look like we're making progress?

Before we break I'd like to have a chance to review the quality recommendations, and then if we want we can try to do an abbreviated lunch break and come back and do the prescription drug chapter.

MS. DOCTEUR: You should have received a packet with the revised recommendations this morning on your chairs. The first recommendation was revised to just add the phrase, evidence based to specify that those are the types of quality measures that we're talking about.

DR. ROWE: You mean minimum? Not minimal.

DR. NEWHOUSE: What's the difference?

DR. ROWE: There's a big difference. This is not the OED here, but it's the minimum data set.

DR. WILENSKY: Right.

MS. FINGOLD: The next recommendation was revised

to add a reference to not just the structural characteristics of the facilities but the processes used. So that was rephrased.

DR. WILENSKY: Could you break that into two sentences? These are two very long and complicated.

MS. FINGOLD: We could take out that last phrase, that to strengthen the evidence basis of Medicare conditions of participation and just describe that more in the -- it's already --

DR. WILENSKY: That's fine.

DR. NEWHOUSE: Maybe if you started the sentence with, that to strengthen phrase.

MS. FINGOLD: Okay, we can move that to the front.

DR. BRAUN: I think there should be a by, b-y, before processes because otherwise it gets hitched into the health care facilities where it doesn't belong. It's by structural characteristics and by processes.

DR. LOOP: To make it a little shorter just say, affected by the structure and process in delivering care. You've got too many words.

DR. ROWE: Why don't you say, to strengthen the evidence base of Medicare's participation, the Secretary should support research -- forget additional, because we're

not supporting all research. Support research on the relation between, and then you just put the variables.

DR. NEWHOUSE: You do need additional because research already exists.

DR. ROWE: But we want the relation between, right?

DR. NEWHOUSE: But you're already supporting that.

DR. ROWE: The structure of health care facilities and the processes used in delivering care. That's the issue.

DR. BRAUN: You want the relation between the health care outcomes.

DR. ROWE: Yes, the relation between outcomes and, et cetera.

DR. WILENSKY: If you have that, can you read it back so we know what the various wordsmiths have --

MS. FINGOLD: Let me try this. To strengthen the evidence basis of Medicare's conditions of participation, the Secretary should support research on the relation between health care outcomes -- I don't have it.

DR. ROWE: You can just say outcomes.

MS. FINGOLD: And structure and process.

DR. LOOP: Structure, process, and outcomes.

DR. NEWHOUSE: I still want additional in there.

DR. WAKEFIELD: I agree. I do, too.

DR. NEWHOUSE: I think instead of by and by, maybe if we had both by, or put a both in there; affected by both structural characteristics and processes.

DR. ROWE: Yes, on the relation between outcomes and both the structural characteristics and processes of care. Then you can take out --

DR. NEWHOUSE: Then can you get rid of health care.

DR. ROWE: -- of health care facilities. You can take out used in delivering.

DR. NEWHOUSE: That sounds good.

MS. FINGOLD: To strengthen the evidence basis of Medicare's conditions of participation, the Secretary should support additional research on the relation --

DR. BRAUN: Support research.

DR. WAKEFIELD: I think additional needs to be there because they already --

MS. FINGOLD: I heard both. Somebody said put it back.

DR. ROWE: Go ahead. You're doing great. Put additional in.

MS. FINGOLD: Leave it in?

DR. WILENSKY: Yes.

MS. FINGOLD: Okay, to strengthen the evidence basis of Medicare's conditions of participation, the Secretary should support additional research on the relation between health care outcomes and both the structural characteristics and processes of care.

DR. ROWE: That's right. Why don't we say instead of additional, say new research? Is that what you want, smaller words?

DR. NEWHOUSE: The problem with new is that projects turn over.

[Simultaneous discussion.]

MS. FINGOLD: The fourth one, we added the ongoing basis to the second sentence in terms of the monitoring should be ongoing to reflect...

MR. MacBAIN: I thought in this one we were also going to include a provision that no facility would be surveyed less frequently than once every five years.

MS. FINGOLD: No, that's in the text. That was not in the recommendation. We did have that in the text.

The next one, number six we revised to request that Congress take steps to assure that the federal

appropriation process not impede the states' ability to fully utilize the funds available.

DR. ROSS: Can we put use instead of fully utilize?

MS. FINGOLD: The point was that they can't always use the full amount that's there. They can use some of them.

MS. RAY: The tenth recommendation is new and addresses your discussion yesterday about a recommendation that the Secretary should take additional steps to make more information about the outcomes of the survey and certification process available to beneficiaries.

DR. ROWE: The results of the survey. The survey doesn't have outcomes. It has results. It's not an implementation of a survey.

MS. RAY: We'll change outcomes to results.

DR. BRAUN: Do we need to take additional steps; the Secretary should make more information?

MS. FINGOLD: There already is available information.

MS. RAY: Yes, on skilled nursing facilities particularly. Yes, there is some information available right now and HCFA --

[Simultaneous discussion.]

MS. FINGOLD: Should make more information about the results of the survey and certification process available to beneficiaries. Okay.

DR. WILENSKY: Why don't we return by 12:45 to take on the prescription drug chapter?

DR. WAKEFIELD: Could I just ask a question? I'm sorry. On draft recommendation six, is it really the case that we want to assure that the federal appropriations process does not impede states' ability to use federal funds appropriated? Is that really what we're -- to use federal funds appropriated? Am I the only one that has a problem? If I am, I'll back right off. But to use federal funds appropriated? I don't think that's -- I think that the wording is a little bit off here.

It's not an ordering issue. I don't think that's the point of our -- that we were discussing yesterday, but I don't have a better -- I'd like to look at this I guess. Could I look at this and come back to it?

DR. WILENSKY: Yes, we can come back to it at --

DR. WAKEFIELD: If I'm the only one with a problem then I'll back off, but there's something wrong with this.

MR. MacBAIN: You're right.

DR. WAKEFIELD: Lu will fix it.

DR. WILENSKY: We'll have public comment and then we want to return --

MS. FISHER: Karen Fisher from the Association of American Medical Colleges. This is almost more for the record. First, we're happy about the Commission's concern about the outpatient on teaching hospitals. Certainly we're grateful for the transition payments but we're concerned about the negative reductions.

But a little bit in fairness to the HCFA staff to clarify about the IME regressions and what was done for the proposed rule, they did do IME and DSH regressions in the proposed rule and found for some of the models there was statistical significance on the teaching variable, none for the DSH variable. We, of course, then replicated their analyses from the proposed rule and found some other statistical significant variables.

Their rationale for not including an IME adjustment in the proposed rule was a concern about the data and other concerns. In the final rule they did address this issue but it was just hidden under the transitional payment discussion, and it was a fairly scant discussion.

They did rerun the regressions in the final rule

and again found one model which showed a statistical significance on the teaching hospital side and again found no statistical significance on the DSH side. But again decided because of the transitional corridors and because they have a concern about the coding issues not to put in an adjustment. But they also did say they would conduct a comprehensive review as better data came in, et cetera.

We're glad that MedPAC is going to look at this. We think this again is one of those issues almost like with the inpatient IME adjustment that if we can get together a group of technical people, both within HCFA and MedPAC, to agree on the type of model that would be appropriate to use to determine what these cost differences are it would be useful.

I just wanted to clarify that. Thank you.

DR. NEWHOUSE: Karen, did they give a timetable for what they were going to do?

MS. FISHER: I think they're going to do it as soon as when they believe the data come in -- after July 1st.

DR. NEWHOUSE: Is that like the next 12 months or is that way off?

MS. FISHER: We're hoping it's before the

transition period ends, that's for sure. We think when the transition period ends that they should have a decision on that.

MS. WILLIAMS: Deborah Williams, American Hospital Association. I wanted to talk very briefly about the operational issues in the outpatient PPS and then we can have much longer, more tedious discussions with staff, which I'm sure they'll enjoy. Well, maybe not.

I think the first, as you know, the major change is the coinsurance, and as you know the outpatient coinsurance is especially complicated because it varies by APC, it varies by the wage index, it varies whether you have multiple surgeries on the same day, it varies on whether there's a deductible paid or not, and it varies whether or not there's a transitional add-on payment for drug or not, and it varies according to the inpatient premium.

Having said that, the way the process works is the bill goes from the hospital to the intermediary, and then for about 80 percent I would -- and I'm just guesstimating -- of all coinsurance then is sent directly to the trading partners who are the Medigap plans, the major employers, and the state Medicaid plans. What conversations HCFA has had with those entities to make sure that they understand the

process, I can't speak to at all. But I think that's important.

Now the beneficiary, of course, gets three pieces of information. They get their bill, a financial statement from the hospital, they get the Medicare summary notice from the intermediary. I assume they get something from these other entities. As far as for the remaining 14 percent or so that don't have Medigap insurance, the hospital will collect coinsurance from them.

What we need in order to do that is two pieces of software: an outpatient code editor which assigns APCs, does all the CCI edits and stuff, and a pricer. We don't have today, despite the fact -- and to a certain extent it's irrelevant to the proposed in September '98, we don't have the software right now. We just don't have it. We think we'll have the outpatient code editor available in a couple weeks. I don't know about the pricer. I have no idea.

Now for the general level of confusion, the constructive opinion from the hospital field that we gave to HCFA that's on the web site is that intermediaries pull all claims if the intermediaries aren't ready. HCFA has said to us, or at least has indicated they find that to be a constructive suggestion. So all I can tell you is, we are

working day and night to make sure that the system is implemented in time, and if not there are contingencies set up for it. Thanks.

MS. REED: Kathy Reed for the Florida Hospital Association. Backing up with what Deb said on the coinsurance, I want to touch coinsurance and also the undercoding, right-coding, downcoding, whatever the word of the day is.

But first of all on the coinsurance issue, the one thing that for that small percentage of the Medicare beneficiaries where the hospital is actually doing the direct collection from the patient -- and I think Deb mentioned that it might be somewhere between about 14 and 20 percent -- you have two issues. First of all, that number narrows because you do have a volume of beneficiaries within that 20 percent that will not be paying coinsurance because they'll qualify for a charity adjustment from the hospital.

We then have a much narrower range of people where we are actually doing the billing, and although we are attempting to collect at the time of service based upon the information that we've been provided by the Medicare program, there is a Medicare summary notice confirmation of the coinsurance amount that is sent to the Medicare

beneficiary saying, this is what you should pay. And that there is some responsibility on the part of the Medicare beneficiary to have some coordination in there that they are paying the right amount.

Secondly on the issue of the coding, need to be aware that the guidelines for coding hospital claims are going to be changing dramatically July 1. There is information in terms of the way we have been coding historically, whether it be for clinic visits, emergency room claims, surgeries, things like that. All of those are going to change. Historically we have for clinic and emergency room visits had a series of five codes that we could use for each. We've only been required to use the lowest possible code.

So if you then go in and do a coding analysis to see what kind of coding changes have happened, there is going to be significant change in the coding levels that have occurred. We urge you that before you start looking at coding that you at least have this program in operation for a year and you compare future years to the base year or something like that, but that you not go back to what happened before July 1, 2000 because the rules do change dramatically.

Thank you.

DR. NEWHOUSE: Let me remark on that last point. The issue is going to be what HCFA normed their payment structure to in this initial year in terms of underpayment, overpayment, or right payment, and I don't know the answer to that question. But as in the initial year of PPS, there was a large overpayment.

MS. REED: I think what you'll find is that they threw all those claims out of their base. Like for instance, when you have a patient who had two surgical procedures, they threw those out of their analysis in terms of coming up with rates.

DR. NEWHOUSE: Yes. I was going to the point that we should ignore what went on with respect to coding in the first year of the system. I don't think we can responsibly do that.

DR. WILENSKY: It is now 12:15. Can we try to reconvene by no later than 1:00?

[Whereupon, at 12:16 p.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION [1:05 p.m.]

DR. WILENSKY: For those who may not have been here yesterday when the announcement was made, the prescription drug discussion will be the last discussion of today. We will not be doing a discussion of the skilled nursing facility reg because it was just received a short while ago. Information about the reg and comments about it, draft comments will be distributed to the commissioners for your review and then will be submitted. But we will not be having a discussion today.

DR. HARRISON: This is the last in a series of three discussion on the prescription drug chapter and today we're going to focus on the third section of the chapter. You have the draft. We're basically going to show you just the things you haven't seen before including some new data that Chantal will show you later.

This section discusses several different general approaches that have been suggested to improve prescription drug coverage for Medicare beneficiaries. Last month we discussed the issues surrounding the inclusion of an outpatient prescription drug benefit within the Medicare benefit and today we'll discuss the other approaches. These approaches have been suggested both as permanent solutions and as interim steps toward inclusion of prescription drugs as a basic Medicare benefit under a reformed Medicare system. The approaches listed here are not meant to be either exclusive or exhaustive and they simply serve as examples upon which to discuss some of the issues.

About 11 percent of Medicare beneficiaries are also Medicaid recipients. These dual eligibles receive their state's full Medicaid prescription drug benefit. Some people have thought to use the Medicaid program as a vehicle to expand coverage for Medicare eligibles, and there are a few other groups of Medicare beneficiaries that receive benefits through state Medicaid programs. They include the QMBs, the SLIMBs, QI1's and QI2's.

The benefits they receive range from the Part B premium plus all the copays for the QMBs, and QMBs have incomes no higher than the poverty level. And there's

smaller benefits for the QI2's, who get about $1.75 a month to cover the portion of the premium that was attributable to the home health shift and they have incomes as high as 175 percent of poverty.

If Medicaid were to be used as a vehicle to broaden the prescription drug coverage of Medicare beneficiaries, the fact that these groups have been set up for other purposes make a quick implementation possible. Policymakers could just pick a poverty level from 100, 120, 135 or 175 and extend the Medicaid prescription drug benefit to these people under whatever level they chose.

While a system could be up and running quickly, there's no guarantee that eligible beneficiaries would sign up quickly. A large percentage of beneficiaries thought to be eligible for the QMB and SLIMB benefits have not signed up. Something like a third of those thought to be eligible for QMBs have not signed up and I think I've seen that only 10 percent of those eligible for SLIMB benefits have signed up. Now of course, adding prescription drugs as a benefit might boost the enrollment in these programs. Could boost the cost as well as the coverage.

Now the states themselves may not react enthusiastically to new coverage requirements. The big

question there would be, will the federal government pay for all the new benefits or will the states be required to match. I'm sure that would influence things quite a bit.

While using the Medicaid program structure allows policymakers to avoid addressing benefit design issues, it would most likely place a larger segment of the country's population under Medicaid's pricing structure, including the controversial rebate program. At least controversial from the manufacturers' point of view. The Medicaid rebate program for all intents and purposes results in Medicaid programs being assured that manufacturers will provide drugs at the lowest price they charge any non-governmental purchaser in the country. This limits the discounts that private purchasers can negotiate with manufacturers since any discount granted to a purchaser would have to be passed along to the entire Medicaid population.

Another approach suggested would have the federal government make grants to the states to provide prescription drug coverage to Medicare beneficiaries. A similar approach has been taken to help provide health insurance coverage to children through the SCHIP program. The current SCHIP program provides federal matching funds to states to provide benefits that meet certain requirements through either

private insurers or through Medicaid. Also there are eligibility standards based on income limits.

Because most states would have to establish new programs, this approach would probably take longer to implement than would a Medicaid-based program. As a reference, even though SCHIP was established in BBA '97, 10 states have not spent any funds as of the beginning of the year 2000.

Although it wouldn't have to be, this approach would probably be targeted to low income beneficiaries. And in fact some states have gotten ahead; 16 states currently have their own pharmacy assistance programs targeted to help low income beneficiaries. They tend to be in the northeast and the benefits vary, and they're usually targeted to fairly low income groups.

This approach could allow greater flexibility for the states to administer their programs now under Medicaid and it would remove the necessity for federal decisions on benefit design. However, federal policymakers would still have to develop the eligibility and benefits standards.

This approach could allow states to use the private insurance market to provide coverage as it happens under SCHIP. Because this coverage would probably be

heavily subsidized, insurers might be less afraid of selection problems, and we'll discuss the selection problems when we get to Medigap. However, to the best of our knowledge, none of the states with pharmaceutical assistance programs yet contract with private insurers.

Naturally, if states design and administer the programs there will be variation in eligibility and coverage. The resulting variation could lead to both innovative improvements and to protests about inequity between the states.

Another general approach would involve using the income tax code to subsidize the purchase of private prescription drug insurance. Subsidy could take the form of a tax deduction or a tax credit. Because the only action needed to begin the program would be to change the tax statute, this approach could also be implemented pretty quickly.

While subsidies could be targeted to low income beneficiaries and/or beneficiaries with high costs, it might be difficult to effectively provide subsidies to low income groups. Many low income beneficiaries do not file tax returns, so even if a refundable tax credit were available, substantial outreach measures would be needed to educate

beneficiaries to file for the credit.

Further, low income beneficiaries may not have the necessary resources available at the time they actually need to purchase the coverage in order to qualify for the credit. Some have suggested that vouchers for insurance could be issued as a prepayment of the credit. Such a strategy would add to the complexity of the approach and the time needed to implement it however.

While tax credits would be administered by the federal government all of the insurance decisions, aside from deciding what would qualify for the tax credit, would be made by the private market. If the policies needed to trigger the credit were drug-only policy however, the private market would still have selection issues to deal with.

The last approach that we're going to talk about right now is to use the Medigap market as a vehicle for enhancing drug coverage. As you might know, reliable information on the Medigap market is very thin. Chantal has recently gotten an NAIC database and she's going to tell you what she found.

DR. WORZALA: This is a little bit of a digression but hopefully it will help inform the discussion. The

National Association of Insurance Commissioners, NAIC, collects from the states the Medicare supplement experience exhibit filings from insurers. The major purpose of the filings is to determine whether or not insurers are meeting their loss ratio requirements. However, these data also include information about covered lives, earned premiums, and certain plan characteristics.

We have conducted an analysis of the filings reported as of December 31st, 1998. I'll present some preliminary findings regarding the distribution of covered lives across the various types of Medigap plans, including those with drug coverage. We also plan to use this data to get at premiums across plan types but have decided against presenting the results due to methodological issues. We do hope to pursue the premium analysis further.

To begin with I'd like to make very short points about the analysis. First, it's self-reported data from the insurers. Second, the raw data set was about 10.7 million lives. We've limited our analysis to plans with at least 50 covered lives because of anomalies in the data. About 2 percent of covered lives were lost when this criterion was applied.

Second, there is some missing data regarding which

Medigap plan type is being reported. We called some insurers to verify the plan type and inserted missing values where we could. In our final data set, less than 1 percent were in plans still missing their plan type.

Given that quick summary of our methods, let me show you what we found. The Medigap market consists of three large categories. Prestandardized policies were sold before the OBRA '90 standardized requirements were put into effect. There are 10 standardized Medigap plans that offer various combinations of benefits, three of which include drug coverage. They've been sold since 1992.

Three states obtained waivers from the OBRA '90 standardization requirements because they had standards that pre-dated the legislation. There is an issue in the NAIC data set of individuals being listed as having a waiver state policy while not residing in a waiver state. Some of this may represent movement of beneficiaries to waiver states. We did our best to clean this variable by, for example, checking to see if the policy was actually a prestandardized policy and was miscoded. However, it does remain a bit of an issue in the data set.

Our analysis showed that prestandardized policies still make up a large share of the market; approximately 35

percent. The share of prestandardized policies decreases with every year as they can no longer be issued. I should not that these policies may be under-represented in the data set because the plans that we threw out with less than 50 covered lives were more likely to be prestandardized policies. Also you might think that those missing plan type are more like to be prestandardized and that insurers with only prestandardized plans may be less likely to file.

The majority of people with Medigap plans have standardized plans. That's about 60 percent of the covered lives. And about 5 percent of the covered lives were listed as part of the waiver states. This may be overstated, as I mentioned.

A word of caution in looking at these numbers. A covered life does not equal a Medicare beneficiary. You can have more than one prestandardized policy, and in fact holding duplicate policies was one of the reasons why they went to the standardized policies. It is, however, against the law to sell duplicative standardized Medigap policies.

Now turning to drug coverage in the Medigap policies. For prestandardized policies the coverage of drugs is really unclear. There's very little data on it. However, one large insurer says that about one in five of

their prestandardized plans has coverage for drugs. These plans are generally thought to have low levels of drug coverage with, for example, $500 benefit limits.

In the waiver states, both Wisconsin and Minnesota have optional drug riders that tend to be expensive and are not widely offered by insurers, or purchased very often by beneficiaries. Wisconsin also has catastrophic coverage in its core plan. Massachusetts has a greater share of beneficiaries purchasing their drug plan, perhaps because the state requires open enrollment on an annual basis for Medigap policies. Again, in all the waiver states premiums for the drug plans are substantially higher.

Within the standardized plans, three of the 10 have drug coverage. Two are low option and one is high option. You can see from the second pie chart that few beneficiaries choose to purchase the Medigap policies with drug coverage; about 7 to 8 percent overall. There are a number of explanations for this. These policies are generally underwritten so often they can't be obtained by beneficiaries.

Also, not many insurers choose to offer them. And finally, they tend to have higher premiums. Our preliminary analysis of the NAIC premium data does suggest that they are

more expensive, but at this point in time we're really not willing to get specific about that analysis.

However, you cannot attribute differences in premiums only to the cost of the drug benefit because the plans do differ with regard to other benefits offered and also there's likely to be adverse selection into the plans with drug coverage. So that assuming that those who plan to use drugs also use more medical services, the selection effect could increase premiums above increases that would be due only to drug use. So there may be increased medical use as well that would lead to increased premiums.

This analysis was meant to provide some background on the Medigap market. I'll turn the discussion back over to Scott to further discuss the option of using Medigap as a vehicle.

DR. HARRISON: A policy using the Medigap market could be implemented quickly but a few structural decisions would really have to be made first. The two biggest structural decisions would be, should the policies currently held by Medicare beneficiaries be grandfathered, allowing them to continue in force? And two, should a drug benefit be incorporated into the core Medigap package which is included in all standard packages, or should it be included

only in a few of the new plans? How those questions are answered would determine which beneficiaries would benefit from including enhanced drug coverage under the Medigap plans.

If policies were grandfathered, then all current policyholders would be at least as well off in the short term as they are now, plus they would have the option of buying a new policy with the new drug coverage. Purchasers of the new policies could face higher prices for a while if the healthy were to stay in the old plans while those who needed drug coverage joined the new plans.

Then how the enhanced drug coverage is incorporated across plans will impact selection between different new plans. At the extreme, if the enhanced benefit is added only to some standardized packages, those packages are likely to fact unfavorable selection for the reasons Chantal discussed.

Some insurance experts have suggested that selection could be reduced in a couple ways. If beneficiaries face a one time in or out choice to buy the drug coverage then selection would be less of a problem than if beneficiaries could buy it only when they knew they would need to use it. Another way to reduce selection problems

across new plans would be to make a drug benefit part of the core package. If the beneficiaries could not make separate decisions on the drug portion of the benefit then no adverse selection could result from those decisions.

On the other hand, if drugs had to be included in all the packages, the price of the packages would have to rise. That price rise could result in further increases because of selection differences between those who choose a plan versus those who choose new plans.

With that, I'll turn it back over to you for discussion.

DR. LOOP: This was a good chapter. I wonder just for presentation purposes if you might develop a table or a matrix showing the advantages and disadvantages of the various proposals. You've got some good graphics in there and if you add a table to that it might make it even more clear.

The other point that I have is that you talked a lot about beneficiaries, but on the providers' side there's a big impact that could be made on the physicians. Their time is being misused by an increasing number of forms. There's a big hassle factor about drugs today. It's getting worse; drugs allowed, not allowed, therapeutic exchanges.

And many physicians -- and you did mention this in the chapter, are concerned about the conflict of interest with manufacturers owning PBMs. I think somehow the hassle factor, try to reduce the paperwork on the providers' side would be helpful.

MS. ROSENBLATT: I too thought this was a very good chapter and I've just got a couple of minor points actually. First of all, when you were talking about this self-reported data, Chantal, you were using annual statements, right?

DR. WORZALA: That's correct.

MS. ROSENBLATT: Just for the record, the annual statements are the most serious document other than SEC filings that insurance companies file. So it's a very valid source of information and I just want to make sure that everybody stand that. It's a very serious source of information.

DR. WORZALA: Right, maybe if I can just explain myself. I didn't meant that with regard to the financial data, but with some of the plan characteristics which are not scrutinized as much. For example, on plan type, 5 percent of the data is missing that.

MS. ROSENBLATT: The other couple of specific

comments, on Figure 8 which follows page eight of the text you've got a very good chart showing typical cost sharing by source of coverage. In your annual premium contribution the employer plan shows $500 to $600 which is the employee portion only I believe. So it looks very weird versus the $2,000 to $4,500 for Medigap which is the full premium. I just think that you'd make that clearer by adding the employer share as well so that you could compare total premium to total premium.

The other comment I had, on page 14 when you were talking about the analysis that you still want to do it looks like you took a preliminary stab at an analysis comparing the premium for, let's say a plan without drugs to a plan with drugs. I think what may be messing you up is that you're doing that nationally. If you have a couple of high cost states where the plans with drugs are not offered, doing it nationally is going to be a problem. So my recommendation would be to focus on particular areas and just look at maybe New York and a couple of other states and see what you end up with there.

There was a chart that had the premium for each plan, and I don't know how --

DR. HARRISON: Those premiums have --

MS. ROSENBLATT: Have the same problem.

DR. HARRISON: -- the methodological problems, right.

MS. ROSENBLATT: I was going to suggest that. Then just one more tone thing, on pages 61 and 62 there are comments on both pages about insurers having little incentive to manage the prescription drug benefit. It's sort of in the middle of page 61, have little incentive to manage the benefit.

I think that's a tone issue. That really there's little ability to manage the benefit because you can't do a three-tier copay or things like that. So if you could just change the wording instead of saying little incentive to little ability I think the tone would be a lot better. You've got a similar problem in the next to last paragraph on page 62.

Thank you.

DR. ROWE: A couple clinical comments. On page five you say that the death rate from atherosclerosis has declined 74 percent due to the advent of beta blockers and ACE inhibitors. I think Dr. Loop would disagree. He's probably saved a few lives in the operating room. A fair amount of coronary artery angioplasty has been attributed --

I think a fair amount of this has been attributed to technologies other than these drugs.

So we might say instead of, due to that, we might just, due in part, or contributing to this has been -- particularly troublesome, Chantal, is the beta blocker because while they really work for people who have had a heart attack, they're not used. They just don't get distributed. The data indicate that it's one of the very effective preventive measures that is not widely enough used.

The last sentence indicates that hormone replacement therapy has been shown to reduce the risk of osteoporosis and heart disease. That was correct until last week when, unfortunately, the new data suggested that it may increase the risk of heart disease. So it's just a little unclear.

So I think that we might want also to add a couple other diseases here that had really major breakthroughs. Peptic ulcer disease, which used to require hospitalization now gets treated with oral antibiotics. Migraine headache, been major advances. Many forms of allergy and arthritis there have been -- so we can list some diseases without listing the specific medicines that I think have been very

effective.

The other thing I would say is that on page six there's a paragraph about direct to the consumer advertising, which is really a hot issue. A lot of people -- Woody was saying that in his plan he thinks that direct to the consumer advertising is responsible for a certain agent being the most prescribed agent amongst people who are building our cars.

I think it might be worth indicating here that Congress passed a law, I think it was two or three years ago, that permitted this. That previously it was illegal to do this. Because people are wondering why all of a sudden there's so much -- the TV and radio are replete with all these ads. We didn't used to have these. That this is in response to a specific change in the law. It is legal to do this and it didn't use to be. I think just a sentence about that might be helpful to helping people understand what's going on.

I had one other thing and that is I know we don't want to get in between Congress and the White House or the administration and the current -- every week there's going to be a new proposal about drug benefits. We had one this week. But there has been -- last week there was a law

passed in Vermont that put a cap on the price of prescription drugs --

MS. RAPHAEL: Maine.

DR. ROWE: Maine. At the Canadian, I think it is -- using the Canadian price as the --

MR. MacBAIN: You can't sell for more than you can buy the same drug in Canada.

DR. NEWHOUSE: The governor is going to veto that.

DR. LEWERS: That's Vermont.

DR. NEWHOUSE: No, it's also Maine; both.

MS. NEWPORT: There's a U.S. senator that's got something similar.

DR. ROWE: So I think it would be interesting -- there's actually a senatorial candidate up in Montana who's gathering old people in buses and taking them to Canada to buy their drugs as a kind of campaign gimmick. I think it would be interesting in the beginning to just indicate that some states are actually passing legislation or considering legislation, a variety of price controls, et cetera, to give a little more context to the kinds of ideas that are coming up.

DR. LOOP: Just back to atherosclerosis for a second. In an effort to avoid interspecialty controversy,

just put down new technology in pharmaceuticals. That will take care of it.

MS. NEWPORT: I thought this has been a very strong effort. A couple of points I think for clarity. One of the issues, and Jack just went into it a little bit but I want to extend it is, one of the challenges -- and I don't know how you address this in the chapter maybe, but acknowledging it, is if you take a federal benefit and have part of it administered in a different way through the states you get a great deal of variability.

For Medicare+Choice an existing pharmacy coverage and benefits in those programs, one of the things that we really think is important is preemption of state law, so you have a uniform base upon which to build your benefit. And for plans like PacifiCare, since we have a national benefit management company that's wholly owned by us, it makes it easier to get as much efficiency out of our structure and our management as possible, and I think it's key to understand that.

So I think it's a very positive thing, and I think you don't want to not even appearing -- you're trying to be very careful not tilting towards one thing or another, but acknowledge somehow that there are some things there that

could decrease efficiencies in pricing and the breadth of benefits inadvertently.

I think also in the chapter, 37 and 38, when I read your description of Medicare+Choice formularies, it's there but it's not quite accurate and on point in terms of the tone. I think that things, for example, beneficiaries getting different prices in different parts of the country, Medicare+Choice, much less their pharmacy, it varies across the country regardless of whether you're in a health plan or you're buying fee-for-service or you're got Medigap coverage.

I think also, and I'm happy if it would be helpful to talk to a couple of folks, our pharmacy benefit managers about how we structure formularies. One of the reasons you're seeing three-tier formularies now, which are very inexpensive generic coverage, branded generic coverage differential, and maybe an open-ended benefit where you pay much higher copay, that was driven by consumer demand at one level. Price changes and price increases on the pharmacy were another driver of that. I want to make sure I link that up, not miss that.

But I think that some of this was in response to consumers wanted to buy proprietary branded drugs and we

felt it was appropriate to do that. So a lot of different factors have driven an evolution in the scope of the benefit and it's a much broader benefit sometimes than I think people think formularies are, at least for my company and I can only speak on that basis.

So anyway, I think those are a couple of areas where I think the impact, possible chilling impact state variability and regulation could have on this at one level, and then really have formularies evolve and are managed is I think important to distinguish it at some level. Maybe even just a footnote.

DR. KEMPER: I'll pile on with the praise for the chapter. I confess to being somewhat skeptical when it was originally in the analysis plan about getting into what we could contribute to a discussion of such a political issue. I think this is a good example of a way in which we can make a very big contribution to an issue that has a lot of political issues that we didn't get into, but still very useful. So I commend you on that.

In that vein, I thought there were three points that the data and discussion laid the foundation to make but it would be useful to really draw them out and highlight them up front so they don't get missed. One is that rapid

advances in pharmaceutical have created treatment opportunities for improving health but also raised cost. I think a lot of people believe there's going to be explosive growth in the future in drug costs. So it seems to me everybody is trying to figure out who's going to pay for it and trying to figure out somebody other than themselves to pay for it, and that really is an important piece here that is underlying this.

Second point is that somewhere between half and two-thirds of beneficiaries already have drug coverage. That means that a new benefit would substitute for an existing benefit. So a lot of what would happen would be changes in payers as a result of a new benefit. I think that point shouldn't -- the data are there but that implication shouldn't get lost.

The third is that a drub benefit is not a simple matter and the details of how it's structured are really important. And there's a lot of them and they're all going to have to be resolved if there's a new benefit. I think just highlighting that complexity is a useful contribution. So speaking for myself, I'd like to see those points brought out.

The second comment is, at one point -- and I

marked it here and I can give it to you -- you are agnostic about the possibility of this benefit paying for itself. You sort of say, it's not clear how big the savings would be from offering a drug benefit, and it's clear in some cases there would be savings in other parts of the health system. But I think we should be clear that offering a drug benefit isn't going to save so much that it would pay for itself.

I guess the third comment is, there are places at which you talk about PBMs and formularies and so on as if they take away beneficiaries' choice of drugs. I think that's a little bit of a strong statement since there isn't a drug benefit yet, so that there isn't really a choice being taken away. It may be a modern management technique that has to be part of, or could be part of a drug benefit in order to make it possible to offer the benefit so that the costs are controlled.

The last comment is just going back to Chantal's presentation. I don't know whether you plan to include the NAIC data, but they seemed inconsistent with the pie chart that you've got in there which says over 10 percent have Medigap drug coverage, yet the NAIC data seem to say 7 percent of 60 percent who have a standardized policy -- a much smaller proportion. It's not a big deal, but I think

we need to choose one or the other.

DR. WORZALA: Actually that reflects the differences in drug coverage, we think; the differences in drug coverage between the standardized, the prestandardized, and the waiver. So that when you add up those constituent parts you get a number fairly close to what's presented in the text, which is from a different data source. So for example, we think that 20 percent of the people with prestandardized policies have drug coverage.

DR. KEMPER: I understood you to say it was very small.

DR. MYERS: I'd like to, I don't know if challenge is the right word, but to question one of the statements you just made regarding whether the drug benefit will pay for itself. I think there are a couple of different ways to think about that. We know from what you've put in the text and from the literature that a patient taking a certain drug for a certain condition is unlikely to develop complications of that condition that might require hospitalization, emphysema being a great example. And specifically discussed in the text atrial fibrillation is another example. Untreated atrial fibrillation in many elderly patients can lead to heart failure which almost inevitably leads to

hospitalization, et cetera.

So in those cases I think it is relatively clear that that patient having that drug, that drug being used appropriately by that patient under a physician's direction does indeed have an economic benefit with respect to the Medicare program. In that sense I think we would probably agree that it is a cost effective investment.

On the other hand, do we know that that is likely to prolong the patient's life? And with each additional year of life of the beneficiary there will be additional costs long term, which I think is a good thing. So I'm wondering whether or not we can look at it in terms of either classes or drugs, or specific diseases with respect to the savings that would occur within the program for offering a drug benefit. I'm wondering whether or not we could at least discuss the potential of the additional quality adjusted life years or whatever measure you'd like to use that would occur for those patients that successfully treated would have a longer period of time as a result.

So I would wonder then overall whether I could agree with your statement regarding the benefit not paying for itself.

DR. KEMPER: Maybe I misspoke. I didn't mean to

suggest it was a good idea or that it wasn't cost effective in some broader sense. Merely that people aren't giving away drug benefits as part of insurance policies. So that overall it's going to cost something for a drug benefit, though there may be many, many places where, many opportunities for particular conditions where it could save money. But I didn't mean to say that a drug benefit wouldn't be cost effective in some broader sense.

DR. NEWHOUSE: Let me start with this last exchange. I don't mind having some of this in, but in general we can leave the scoring I think to CBO. To Woody's comment, while it's really probably right it's going to depend importantly on who gets the drugs once you put the benefit out there, which we're going to have very little ability to figure out.

Now on Floyd's comment on paperwork I thought could actually come into the discussion you have on pages 50 and 51 on selection of PBMs. There is a debate that I'm on one side of between whether you should have single PBMs or multiple PBMs in a local area. Multiple PBMs are very likely to produce multiple formularies, which will increase the paperwork. Whereas a single PBM with competing the contract every few years, potentially produces a change

every few years, but given the number of Medicare beneficiaries I suspect everybody who treats Medicare beneficiaries is going to know fairly quickly what the formulary is.

The third point is I thought that, although I liked the chapter also, I thought that you had somewhat underdone the retail distribution side of this. That accounts for 20 percent of the cost roughly of drugs. And there's actually also, I'm told anyway, considerable differences between retail markups in the U.S. and retail markups in Canada. It's not just the manufacturers' price.

One of the issues that comes up then -- I mean, many of the states have, for example, any willing pharmacist laws. How does that play into the selection in Medicare? Is there a preemption of that or not? There's a little discussion on page 35 but it's like two or three sentences and then onward. And then there's a little discussion of mail order too, and I can't remember whether you said anything about the Internet or not.

Then finally one minor comment. You start out early on, on page four I think talking about the streamlined FDA approval process as a reason for the increase in drug approvals, which I agree with. But that's also a one-time

effect. Once we've worked through the backlog, then presumably it will fall back some, and the chapter sets it up as though it will last for a long time. I don't know how long it will last.

DR. LEWERS: I think this is going to be a meaningful contribution to the debate and therefore I request we be as scientific as possible. My colleagues Dr. Rowe and Dr. Loop have commented on technology and drugs. I could challenge the statement that atherosclerosis is what has changed that process. The quote that you have is from testimony that may well have bias, and a lot of bias. I think if we're going to quote diseases, as Jack has said, that have been affected -- and there are several that have been affected by specific agents, then we should have at least some sort of scientific base to cover it and not testimony.

The other element, the DTC, there's a role here that many people forget about, and that is that it's not the drug costs per se, it's the cost of the patient going to the physician and driving the patient to the physician for a condition or a drug that is not appropriate. So we don't mention that at all, that there's an excess cost to that program. We've asked the industry to try to see if they

have any information on what it is doing. There is none, at least none that anybody is talking about. So I think that we need to make sure we have all issues covered.

The other thing that Joe brings up is the point of formularies. There's very good evidence, scientific evidence, that formularies do not save money, and may actually cost money. There's a couple papers on that that are decent papers, recent papers. I think you better look at them and see what you think about them. There are certain ways that formularies can be run that would be beneficial, but all formularies are not effective. So there is some evidence that you need to find and look at that.

MR. MacBAIN: Just a request for clarification. I think I know what's going on here, but at one point you mentioned and I think Peter picked this up too, something like 69 percent of Medicare beneficiaries have drug coverage and yet when you look at the distribution of drug coverage in Medigap policies it gives an impression that practically nobody has it, or if they do they have the minimal coverage in the prestandardized plans. So just to square those two figures. I assume that most of that 69 percent are covered either through Medicaid or employer-sponsored plans.

So the extent that part of that 69 percent is

covered through prestandardized plans, it's either minimal coverage or it's going away over time. So there's a downward trend on that 69 percent. If you'd just mention those two points. It's not quite what it appears.

DR. MYERS: Could I just comment on that point? I would think that if we could create a table it would be very interesting to see the number of patients who have Medigap, and of the patients in Medigap, the percentage of those that have drugs. The number of patients that have employer-sponsored and the percentage of those that have drug coverage, and then any other categories. Then you could see the numbers lined up against each other and you could come to your conclusion that it's either 69 or it's some lower number, because that confused me as well.

MR. MacBAIN: Yes, I'd like to see that although I'm not sure we have the information on the employer-sponsored plans, do we?

DR. HARRISON: Not really, but we can see what we can come up with.

DR. BRAUN: I had some concerns, for one thing about that whole situation. I think we do need to more explicitly point out that the current coverage is often not adequate, it's expensive, and it's also unstable. I think

in another place where you're talking about Medicare+Choice that's one of the unstable parts in that every year those can change or you have withdrawals from the program and so forth. So that even though it sounds like a fairly high percentage, I think the Commonwealth study showed actually over a year's period only 50 percent, a little over 50 percent have coverage all year around and we know that all of that's not adequate.

I also wanted to comment on the Medigap plans that have drugs. I think that all carriers require, not just some, require medical underwriting on the drug plans unless the states prohibit the underwriting.

DR. HARRISON: Right, except during the open enrollment periods. I think that's right.

DR. BRAUN: Because actually I think that the AARP plan were among the later ones to start to use medical underwriting.

MS. ROSENBLATT: Bea, excuse me. I'm not sure all Blue Cross-Blue Shield plans would require medical underwriting, even if the state doesn't require it.

DR. BRAUN: For the drug?

MS. ROSENBLATT: Yes.

DR. BRAUN: I'd be very surprised if they don't.

I'd like to know where they are, if you know that there are some.

[Simultaneous discussion.]

MS. ROSENBLATT: Blue plans always do things that amaze me so...

DR. BRAUN: Blue Cross-Blue Shield in some places require medical underwriting on some of the others, not just the drug plans, so I'd be very surprised. But it would be good to know if there really are some.

In the famous page five that we've discussed a good bit, I'd like to add the fact that I think the changes in lifestyle have also made a difference; the decrease in smoking and hopefully increasing in exercise has made some difference in some of those illnesses as well as the medication and certainly all the new technologies for both diagnosis and treatment.

Also on page 23 where you're discussing lessons that we ought to learn from previous legislation and what happened to it, most typically the catastrophic, I think one of the lessons we need to learn is that beneficiaries need to understand what's happening, because there is organized opposition out there which we've already begun to see. If the beneficiaries don't really understand the impact that

they get from the opposition they'll be against it and they really don't understand what it's all about. So I think the fact that there is organized opposition, not just opposition from individual beneficiaries is important to note.

Also I think on page 54 perhaps where you're defining the benefit package it's important to note the impact of benefit design on risk selection, because I think we have to keep remembering the problem of risk selection as we begin to diversify into a lot of different plans or think about doing that.

I think where you talk about possibly expanding Medicaid -- of course, one of the problems is the outreach and people that are not on the system that could be now. But I think the other problem is that we really need to bring in the fact that middle income beneficiaries also -- I mean, expanding Medicaid will not take care of some of the people who really can't afford the high cost of drugs who are middle income.

I wondered on page 61, the little chart that's on page 61, is that really current data? The premiums to me look pretty low.

DR. WORZALA: That's the premium analysis with the NAIC data that we're looking at again.

DR. BRAUN: That is the present moment?

DR. WORZALA: We're not quite sure.

DR. BRAUN: I think I live in the wrong state if that's --

[Laughter.]

DR. WORZALA: It is 1998 data, not 2000. But as we noted, we have some methodological issues to work out on the premium data.

DR. BRAUN: Because I realize it is an average.

Just one last thing. I had some thoughts also on that chart that comes after page eight and whether it would be good to put something about a range of costs for maybe Medicare+Choice, the generic and the brands, and also something on the three-tier payments rather than just generic and brand, because I think there's more and more motion toward a three-tiered situation.

Are those deductibles, $250 and $500, is that current or is that wrong?

DR. WORZALA: That's incorrect.

DR. BRAUN: I thought possibly it was but I wasn't sure.

MR. SHEA: I think it's a nice piece of work and I want to congratulate the staff on how much work has been

done over the past few months on this. I think this really is a real contribution, and covering so much ground and handling it in a very balanced kind of way. I particularly appreciated what you took from the last conversation and developed in terms of the employer coverage and what's going on there. I thought that was well done.

A couple of suggestions. I thought perhaps a little bit more on the consumer issues would be useful here. In the direct to consumer marketing it's not hard to imagine, and some people are doing some work on this, that maybe there should be some rules if there's going to be this extensive, aggressive advertising there should be some rules about how that advertising should be done. Maybe people could understand what it is, how it was written, and written in way that both had the pluses and minuses as opposed to just pitch marketing, and then all the fine print, of course.

Also there's been some discussion about the notion of requiring drug companies to do more aftermarket tracking and report issues with that through an FDA kind of mechanism. You might want to look at that. Some of this is the work coming out of the prescription drug value project, which if you haven't yet talked to those folks it's worth

doing. They're going to announce their findings in three or four weeks, and I'd urge them, Murray, for these folks to look you up. I don't know whether you've gotten a call from the prescription drug value project, but they're doing a lot of good research around this.

You mention in here the amount of activity on state legislation. I don't know when you drafted that but it just seems to me even in the last couple of weeks there's been a lot of reports about a lot of activity going on. I just want to make sure that you're up to speed as best you can be.

Then on Bea's point about making sure beneficiaries have the right information, maybe we can have a chart about the dualing buses at the border: the bus to Canada and the bus from Canada.

DR. MYERS: The bus to Mexico is actually better because they're about half the price as in Canada.

MR. SHEA: That's because of NAFTA though. We don't want to get into that.

DR. WAKEFIELD: Just to follow up on Gerry's point, that whole issue around direct consumer advertising, other people have mentioned it. It's such a thorny issue for a lot of reasons, and I think to the extent that there's

anything that could be added to that discussion it would be great.

That is it's just hard to strike a balance between informing consumers, which I think ought to be the driver here, but potentially implications for utilization: Floyd's point earlier, provider time that gets consumed in the process. It's just a lot of related issues that deal I think with the three drivers of cost, access, and quality, that you can pin to some facet of direct consumer advertising.

Sometimes I wonder if right behind my Neiman-Marcus catalogue every month I'm going to pretty soon see a catalogue that comes with all my drug options. I'm already seeing it in the Washington Post every day. I can't afford it anyway, so both of them are unaffordable.

But anyway, it's not going to stop. It probably isn't going to lessen. What are some of the fundamental issues that we ought to be looking at around that? Because it does have, at least to my way of thinking, pretty significant implications on the cost, access, quality front.

The other point I was going to make is, Joe, just as an aside your recent article on PBMs by the way is required reading for my class this semester. Just FYI, so I

know your opinion on that topic.

DR. ROWE: Is it an example of a good piece?

[Laughter.]

DR. WAKEFIELD: It's a good piece, absolutely.

MR. SHEA: But is it scientifically grounded; that's what we really want to know?

DR. WAKEFIELD: Theoretical and scientifically grounded, absolutely.

The third and last point actually gets to page 39. Here's another sort of -- of the many complicated issues, on page 39 the discussion of limitations on pharmacy networks, et cetera. I think if you haven't taken a look at it, it might be worth taking a look at, there's a recent article in the Journal of Managed Care -- probably not as scientific and theoretically grounded but -- that reports out a single state study that shows closure of pharmacies when Medicaid changed its purchasing behavior.

I don't know if it's worth your taking a look at or not, but there might be something to glean from that, and also thinking about --

DR. ROWE: Was that New Hampshire?

DR. WAKEFIELD: I can't remember. But it was one state, just one state.

MR. SHEA: New Hampshire is the example that's usually cited of that kind of problem.

DR. WAKEFIELD: Could well be. Anyway, you've got the journal and it's a relatively new publication.

Then, because it begs a little bit of the question, which is beyond where we probably want to get to, but to what extent do we care if local pharmacies close? That's part of what you're getting at in this paragraph. That is, requirements governing the geographic distance between beneficiaries and network pharmacies are an option. So if there's anything more that we can say about the issues around that, maybe it would be worth thinking about. And that's the only source I can direct you to for a little bit more insight perhaps.

MR. MacBAIN: Just an editorial comment, and I don't think anybody mentioned this one. On page 41 you refer to a number of lifestyle drugs, including drugs for anorexia, weight gain, fertility, smoking cessation, and others. Lifestyle might not be the word to use there, because I think you'll get argument on each one of those.

DR. WILENSKY: Thank you. I think there's a general sense that this is a useful paper. Bea, is it an editorial point or an issue?

DR. BRAUN: I think it's more the sense of something -- in a sense that on page 19 where you're dealing with coverage and moral hazard and so forth. It seems to me that that reads a little bit, when you read it, as if everybody is going to run out and buy a lot of drugs. Somehow or other we need to realize that these are only prescription drugs and that actually a lot of this is coming because people will be filling needed prescriptions that they don't fill now because they don't have the money. So somehow I think we need to balance that a little bit.

DR. WILENSKY: Thank you. Thank you very much, Scott.

Before we adjourn we have two recommendations that were being redrafted. Just wanted to show the commissioners where we are and then we will finish. We're going to do a quick look at the recommendations that were rewritten on the SGR in the outpatient.

DR. WORZALA: I've handed out the revisions to all of the recommendations for the outpatient services. You also have a list of bullet points as a second page which is a very -- it's an outline of the points that we would raise in the discussion to accompany the access to care recommendation. So I'll just go through the recommendations

one by one.

DR. NEWHOUSE: On four, the text would just refer to the studies that HCFA had done on the inpatient side? That's what I would suggest.

DR. WORZALA: Do we need to read them out?

DR. WILENSKY: No. If anybody has any further comment they can give them to you but I think this captures what we were talking about.

Thank you. There is a draft recommendation with regard to the physician payment update and it has to do with explaining the changes in traditional Medicare enrollment. I think that says it clearly.

There are several commissioners whose term is rotating and unfortunately, as we indicated yesterday, we do not know what will be the outcome.

DR. ROSS: Before we have a tender moment, Helaine says she has one more recommendation.

DR. WILENSKY: I thought we had decided that was taken care of.

DR. ROSS: I thought we were okay on that.

MS. FINGOLD: We were?

DR. ROSS: That was the long amendment in the nature of a substitute.

DR. WAKEFIELD: Did you create your own or did you look at ours?

MS. FINGOLD: We never saw what you had.

DR. ROSS: Yes, you did. I gave it to you.

DR. WAKEFIELD: We gave it to Murray.

DR. ROSS: Yes, and everyone else has given them their proxy.

DR. WILENSKY: So I think we're okay.

Again, any of the commissioners who would like to attend the July meeting are able to attend the July meeting. If you are not on our reappointment, we would be very glad to have you and have an appropriate acknowledgement of your contributions. Again, I apologize that we are two weeks within the end of the term and we do not know the outcome of the reappointment process, but it is not our doing.

DR. ROWE: You may have to pay your own way.

MR. SHEA: And limit your remarks.

[Laughter.]

DR. WILENSKY: Again, thank you for all of the assistance that you've given us.

DR. NEWHOUSE: That goes for me, too.

DR. WILENSKY: If anyone wants to make a public comment, at this time they may.

Thank you. We will meets officially again in September.

[Whereupon, at 2:08 p.m., the meeting was adjourned.]